TEST REFERRAL FORM

This form is interactive. Please complete and return by email to:
info@londonmedical.co.uk or fax to **+44 (0)207 467 5471**

LondonMedical

49 Marylebone High Street, London W1U 5HJ
Tel: **+44 (0)207 467 5470**

PATIENT DETAILS

Title: Mr/Mrs/Miss/Ms/Other:

Name:

DOB: Sex: M F

Address:

Post Code:

Phone number:

REFERRING CLINICIAN

Name:

Address:

Post Code:

Phone number:

Fax number:

Email:

Referrer's signature **Date**

RESULTS TO: please specify

TESTS REQUIRED

Bloods please specify:

Endocrine Tests please specify:

Diabetes Specialist Nurse

- Diabetes education ☐
- Blood glucose testing & monitoring ☐
- Improving glucose control ☐
- GLP1 agonist initiation ☐
- Continuous glucose monitoring ☐
- Insulin pump teaching ☐

Dietitian

- Weight Management ☐
- Diabetes, glycaemic index ☐
- Carbohydrate counting ☐
- Cholesterol ☐
- Gastroenterology – IBS, coeliac etc ☐
- Polycystic ovaries ☐
- Bariatric surgery (pre/post) ☐
- Other – please specify

Services

- Check-ups, Travel Clinic ☐
- Laser Hair Removal ☐
- Podiatry ☐
- Gastroenterolgy – SmartPill/ Smart capsule/pH monitoring ☐
- Breath tests ☐
- Clinical Psychology ☐
- Sexual Health ☐
- Audiology ☐

Other Tests

- Carotid Ultrasound, intimamedia study ☐
- Echocardiogram ☐
- Exercise ECG ☐
- Resting ECG ☐
- Ultrasound: pelvic, thyroid, Abdomen, other – please specify
- 24hr Ambulatory BP (radial tonometry with central aortic systolic pressure) ☐
- Cardiac monitor ☐
- 24 hour Holter ☐
- 1-14 day R Test ☐
- Arterial/Venous Lower Limb Doppler ☐
- Overnight Pulse Oximetry ☐
- Lung Function Test ☐
- Bone Densitometry ☐
- Injection therapies: in-house pharmacy drugs only

Ophthalmology

- Biometry ☐
- Fluorescein angiography ☐
- Optical coherence tomography ☐
- Visual Fields ☐
- Fundus photograph & report ☐
- Optometry ☐
- PDT ☐
- Intravitreous therapy ☐
- Autorefraction ☐
- Contact lens training ☐