IMAGING REQUEST FORM

EMERSONS GREEN NHS TREATMENT CENTRE
The Brooms, Emersons Green, Bristol, BS16 7FH
Tel: **0117 906 1861** Email: uksh-radiology@nhs.net

PLEASE COMPLETE THIS FORM, SIGN IT AND FAX IT BACK TO: 0117 957 1351

Date:

Name of patient GP:

Name of GP practice:

REFERRER DETAILS

Referred by:

Practice name:

Practice no:

Practice address:

Telephone no:

Fax no:

PATIENT DETAILS

Name: (Title, Forename, Surname)

Address:

Postcode:

Telephone no:

Mobile no:

Date of birth: NHS no:

Gender: Ethnicity:

Examination requested: ☐ **ULTRASOUND**

Body part:

Reason for request/clinical justification:

Relevant previous medical history (inc. previous surgery):

Last menstrual period date (for females aged 12 - 55 referred for all x-rays between the diaphragm and knees):

Is the patient breast feeding?: ☐ **YES** ☐ **NO**

Does the patient have any allergies?: ☐ **YES** ☐ **NO** **if yes please specify:**

REFERRING CLINICIAN SIGNATURE:

(It is a medico-legal requirement that this form is signed by the referring clinician)

IMAGING GUIDELINES In deciding whether a request can by clinically justified the Radiology Department must comply with the RCR Guidelines defined in "Making the best use of a Department of Clinical Radiology".

RADIOLOGIST/RADIOGRAPHER USE ONLY

The patient has confirmed as follows: ARE YOU OR COULD YOU BE PREGNANT? ☐ Yes ☐ No

Signed (Patient) Date Signed (Staff) Date

Patient ID verified: ☐ Yes ☐ No Request clinically justified: ☐ Yes ☐ No If No-Case referred to Radiologist: ☐ Yes ☐ No

EXAM REQUIRED: .....PREP REQUIRED:.....

EXPOSURE/ DOSE: INFORMATION	VIEW	DAP	SCREENING TIME	MAS	KVP	PATIENT SIZE *(circle)* S M L