CT REQUEST FORM

Parkside Hospital & Cancer Centre London	DEPARTMENT OF RADIOLOGY
53 Parkside Wimbledon London SW19 5NX Telephone: 020 8971 8000	**Fax: 020 8947 1526** **Email: radiology@parkside-hospital.co.uk**

Referring Doctor	Patient Details
Doctor:	Surname:
Address:	First Names:
	D.O.B.:
	Clinic No:
	Address:
Tel No:	Tel No:

For female patients aged 12-55 years please enter date of L.M.P.

Is there any possibility you could be pregnant	YES ☐ NO ☐

PLEASE TICK APPROPRIATE BOX:	I/P ROOM NO ☐	O/P ☐	WALK ☐	CHAIR ☐	STRETCHER ☐	PORTABLE ☐	THEATRE ☐

CONTRAST STUDIES REQUIRE SERUM CREATININE / eGFR RESULT (TAKEN WITHIN LAST 3 MONTHS)

CREATININE LEVEL:	**eGFR:**

CLINICAL HISTORY (IRMER requires a full history):	EXAMINATION REQUESTED:

SPECIFIC QUESTION TO BE ANSWERED:

SIGN	DATE	Preferred Radiologist?

NOTE: INCOMPLETE REQUESTS WILL BE RETURNED, RESULTING IN DELAY OF BOOKING. Patients MUST bring outside Imaging for comparison

SAFETY CHECK			For Radiographer use only
Does the patient have?	**YES**	**NO**	**Comments:**
A History of Diabetes? Any	☐	☐	
Allergies?	☐	☐	Patient Dose:
A History of Asthma?	☐	☐	IV Contrast Administered:

CT Colonography - Prescription

ITEM	Prescriber Signature & Date	Prescriber Name & Qualifications
☐ Gastrografin 100ml Bisacodyl 5mg ☐ Tablets		