ALL DETAILS MUST BE COMPLETED IN FULL (FRONT AND BACK) OR THE FORM WILL BE RETURNED

IMAGING REQUEST FORM

PATIENT NAME/LABEL:

ADDRESS:

DATE OF BIRTH:

HOSPITAL NUMBER:

POSTCODE:	HOME NO:	WORK NO:

AREAS TO BE IMAGED:

Creatinine Level …….. Date of test:

EXAMINATION REQUESTED:
If Available:

- X-Ray ☐
- Ultrasound ☐
- MRI (Please see reverse for contra indication) ☐
- CT ☐
- Mammography ☐
- DEXA ☐

CLINICAL DETAILS: Including any surgery and current medication

REFERRER'S NAME:

SIGNATURE:

DATE:

PREVIOUS IMAGING HISTORY:

NUFFIELD		NHS		NONE	

I hereby give consent to the above examination and confirm that the examination procedure has been explained to me.

PATIENT SIGNATURE:	RADIOGRAPHER'S SIGNATURE:
DATE:	DATE:

REFERRER'S DECLARATION
NB: THIS IS A LEGAL DOCUMENT

1. The correct patient details have been entered.

2. I have discussed this examination with the patient/guardian (delete if not relevant).

3. I have taken into account the possibility of pregnancy.

4. I have given sufficient clinical information for the request to be justified according to IR(ME)R 2000.

5. I will ensure that the examination result is recorded in the patient's case notes.

Ignore LMP ruling ☐

SIGNATURE OF DOCTOR

……

I confirm that to the best of my knowledge I am not pregnant.

PATIENT SIGNATURE

……

Is the patient breast feeding?

Is the patient a high infection risk?
If yes please specify.

History of allergies?

APPOINTMENT TIME:
DATE:

INPATIENT:

ROOM NUMBER:

OUTPATIENT:

EXPOSURE FACTORS:	
ROOM:	
MAS:	
KVP:	
DAP METER:	
SCREENING TIME:	
NUMBER OF IMAGES:	
RADIOGRAPHERS SIG:	

FOR IMAGING DEPARTMENT USE ONLY
JUSTIFICATION:
THIS PROCEDURE HAS BEEN JUSTIFIED UNDER THE TERM OF THE IR(ME)R 2000 REGULATIONS

RADIOLOGIST OR RADIOGRAPHER'S SIGNATURE:
BILLING INFORMATION:

MRI SCANNING REQUESTS

ABSOLUTE CONTRA INDICATIONS

Has the patient ever had a cardiac pacemaker or pacing wire?		
Has the patient ever had a cerebral aneurysm clip?		
Does the patient have a cochlear implant?		
Is the patient pregnant?		
If the answer is "YES" to any of the above please discuss with a consultant Radiologist.		
Does the patient have any metal implants/medical devices attached to/in their body?		
Has the patient at any time had a penetrating metal injury to their eyes?		
If the answer is "YES" to either of the above please give full details and contact the MRI department.		
Does the patient have any known renal impairment?		
Is the patient awaiting a liver transplant?		
Has the patient had an eGFR in the last 3 months?		
If so, please state the outcome here?		

NAME:	**SIGNED:**

Please fax your referral form to ***0117 973 3728*** or email to: ***bristol.radiology@nuffieldhealth.com***

The Radiology Department
Nuffield Health Hospital Bristol, The Chesterfield
3 Clifton Hill, Bristol, BS8 1BN
F. ***0117 973 3728*** T. ***0117 906 4878***