X-RAY/ULTRASOUND/NUCLEAR MEDICINE 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.	Justified By:	Dose (kVp/mAs):
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
	☐	☐	☐	☐	☐	☐	☐

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

For Radiographer use only

Comments:	DLR Reading
	Number of projections sent: