

General/CT/MR T:0207 616 7653 (ext: 3350/3353)
F:0207 616 7679
Intervention T:0207 616 7626 (ext: 3075)
Nuclear Med T:0207 535 5544 (ext: 3170/3178)
F:0207 535 5547



Imaging Request

X-ray CT Bone Density
 US MRI Nuclear Med

ALL SECTIONS MUST BE COMPLETED BY THE REFERRER
The Ionising Radiation (Medical Exposure) Regulations 2000 IR(ME)R require you to complete this form accurately. Incomplete/illegible forms may be returned.

Examination Requested

Clinical Indication for examination. Please summarise relevant history, clinical findings and test results. Indicate the question that the examination should answer.

Preferred Radiologist:

Imaging requiring Intravascular Iodinated Contrast Medium (CT, Angiography, Venography, IVU)

Is the patient taking Metformin? Yes No

Is there a history of:

- Reaction to Contrast Medium Yes No
- Asthma Yes No
- Allergy requiring medical treatment Yes No

If the answer is yes to any of the following, Serum Creatinine levels must be provided:

- Angiography is being requested Yes No
 - Known raised serum ceratinine/reduced GFR Yes No
 - Patient is diabetic Yes No
 - Recent Nephrotoxic drugs Yes No
- A history of:
- Kidney disease/surgery Yes No
 - Proteinuria Yes No
 - Hypertension Yes No
 - Coronary Artery Disease Yes No

MR Imaging

If the answer is yes to the following, Serum Creatinine levels must be provided:

- Is there a history of kidney disease/surgery? Yes No
- Is there a history of dialysis? Yes No

Does pt have a Cardiac Pacemaker, Cochlear Implant or Intracranial Aneurysm Clips? Yes No

Serum creatinine/Estimated GFR:	
Date Measured:	

Patient Information

Surname: _____

Forename: _____

Address: D.O.B. _____ M/F _____

Post Code: _____

Telephone: _____

Insurance Co. _____

Policy No. _____

Auth. _____

Hospital No. M L

OP IP DC Room No: _____

Mode of transport:
Walking Bed Trolley Wheelchair Portable

APPOINTMENT

Date	Time

Referrer's name and address or stamp

Contact Number:

N.B. This form is a legal document – Referrer's Declaration

- The correct patient details have been provided.
- I have discussed the examination, including any intervention, with the patient /guardian.
- I have taken into account the possibility of pregnancy.
- I have given sufficient clinical information for the request to be justified according to IR(ME)R 2000.
- I will ensure that the examination results are recorded in the patient's notes.

Referrer's Signature:

Date:





FOR COMPLETION BY THE IMAGING DEPARTMENT

Patient ID Sticker

Safety Information (to be completed with the patient)

Do you think you might be pregnant Yes No

LMP _____
(for female patients 12-60 yrs, examinations between the knees and diaphragm only)

I declare that I am not pregnant

Signature: _____ Date: _____

Has the ID been checked? Yes No

IR(ME)R (not applicable to MRI/Ultrasound)

Duty Holder

Signature: _____

a) The Practitioner

Date: _____

b) The Operator

OR

c) Operator authorising on behalf of the Practitioner

Operator Use	DAP (cGycm ²)	DLP (mGycm)	Fluoro time
	Other, please specify unit		

Contrast Medium, Radiopharmaceutical, Drug Used	Volume	Expiry Date	Lot No	Activity (MBq)	Injected By	Time

Authorised by: _____

Radiologists Protocol:

Operators Comments

