Diagnostic Imaging Referral

OSD Healthcare

Patient details

Surname..... First name.....

DOB..... Male ☐ Female ☐

Membership number.....

Address.....

..... Postcode.....

Phone (M)..... (H).....

Email.....

Interpreter required: Yes ☐ No ☐ Language.....

Requested procedure

MRI ☐ Dental (OPG/CBCT) ☐

CT ☐ Ultrasound ☐

X-ray ☐ Other ☐

Please provide details of the procedure(s).....

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Payment details

Payment method: Insurance ☐ Self-pay ☐

Payment provider.....

Special instructions

Book scan for week commencing...../...../.....

Result of scan required by...../...../.....

Specific Radiologist required.....

Additional information

Patient transport: Walking ☐ Wheelchair ☐ Bed ☐

Infection risk: Yes ☐ No ☐ Details.....

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Allergies.....

	Yes	No	
Pregnant:	☐	☐	Last menstrual period.....
Asthma:	☐	☐	Weight kg..... Height.....

CT/MRI:	Yes	No
Recent surgery	☐	☐
Please specify.....		
Reaction to contrast media	☐	☐
Kidney disease/surgery	☐	☐
Dialysis	☐	☐

eGFR: mL/min...../...../.....

Creatine: mL/min...../...../.....

MRI:	Yes	No
Claustrophobic	☐	☐
Metallic fragments in body	☐	☐
Cardiac pacemaker/ICD	☐	☐
Colchlear implant	☐	☐
Intracranial aneurysm	☐	☐
Other metallic implants	☐	☐

Clinical indication for examination (please summarise relevant history, clinical findings and test results)

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Referrer name.....

GMC.....

Address.....

..... Postcode.....

Tel..... Email.....

Signature:

Date...../...../.....

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

The correct patient details have been provided. I have discussed the examination, including any intervation 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 2017 (if applicable). I will ensure that the examination results are recorded in the patients' notes.

To be completed by staff only

Imaging approved.....

Authorising person.....

Signature..... Date...../...../.....