

Diagnostic Imaging Referral

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).....

Payment details

Payment method: Insurance Self-pay
 Payment provider.....

Special instructions

Bookscan for week commencing...../...../.....
 Result of scan required by...../...../.....
 Specific Radiologist required.....

Additional information

Patient transport: Walking Wheelchair Bed
 Infection risk: Yes No Details.....

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

CT/MRI:

	Yes	No
Recent surgery	<input type="checkbox"/>	<input type="checkbox"/>
Please specify.....		
Reaction to contrast media	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease/surgery	<input type="checkbox"/>	<input type="checkbox"/>
Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
eGFR: mL/min...../...../.....		
Creatine: mL/min...../...../.....		

MRI:

	Yes	No
Claustrophobic	<input type="checkbox"/>	<input type="checkbox"/>
Metallic fragments in body	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac pacemaker/ICD	<input type="checkbox"/>	<input type="checkbox"/>
Colchlear implant	<input type="checkbox"/>	<input type="checkbox"/>
Intracranial aneurysm	<input type="checkbox"/>	<input type="checkbox"/>
Other metallic implants	<input type="checkbox"/>	<input type="checkbox"/>

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 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 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...../...../.....