Duchy Hospital
Penventinnie Lane, TRURO TR1 3UP
Tel: 01872 226106
Fax: 01872 226129

Radiology Referral Form

People caring for people

RAMSAY HEALTH CARE

Patient Information

Hospital Number DOB

NHS Number

Surname

First Name

Address

Post Code
Tel: (H) (Mob)
Permission to contact patient by telephone or to leave a message
Yes No

In Patient ☐ Outpatient ☐ GP ☐

Self-funding ☐ NHS funding ☐ Insured ☐

Medico-legal ☐ Research ☐

Walking ☐ Chair ☐ Bed ☐ Portable ☐ Theatre ☐

Insurance Company ..... Price quoted £.....

Previous X-ray

Date referral received

L.M.P. (where relevant)

I certify that today I was asked if there was a possibility of my being pregnant and there is no such possibility
Signed Date

If L.M.P. to be ignored
Signed Date

Examination

Xray ☐ Ultrasound ☐ MRI ☐ CT ☐

Nuclear Med ☐ Dexa ☐ Mammo ☐

Clinical Details

Referrer Name and Address

Signed Date

The Ionising Radiation Regulations 2000 (IR(ME)R) require you to complete all this information accurately. Incomplete/illegible forms may be returned.

If a contrast injection is required this must be completed:

Glaucoma	Y / N	Previous contrast reaction	Y / N
Diabetic	Y / N	Taking Metformin	Y / N
Myeloma	Y / N	Renal Failure	Y / N

Creatinine level (within last six months)

Consent where applicable: This procedure has been explained to me and I agree to proceed.

Signed Date

Appointment Date/Time

Referral Information

Radiologist Referred to:

Examination Justified by:

Protocol:

Radiographer Information

Dose:

Screening time:

Number of exposures:

Films:

Date of procedure:

Radiographer's signature: