Oaks Hospital Radiology Referral Form for MRI/CT/X-Ray/Ultrasound

Patient Information

Hospital No. DOB

Surname

Forename

Address

Postcode Tel.

Permission to call/leave message Y / N

Appointment

Date

Time

Date of previous imaging

Walking ☐

Wheelchair ☐ Portable ☐

Bed/Trolley ☐ Theatre ☐

Inpatient ☐ Outpatient ☐

Examination

Radiologist referred to:

Justified to:

Protocol/Comment

Clinical Information and Question to be Answered

Referral Details

Referrers Name (please print)

Address

Signed Date

The Ionising Radiation (medical exposure) Regulations (IRMER) 2000 require you to complete all the information

Incomplete/illegible forms will be returned.

Bowel Preparation (to be completed by referrer)

Please state any medical conditions that would contra-indicate use of bowel preparation agents if relevant (e.g. reduced renal function):

Billing

Self-funding ☐ Insured ☐

Medico-legal ☐ NHS ☐

Insurance company & price quoted

LMP (if required) Date

LMP to be ignored

Clinicians signature

Date

I certify that there is no possibility I am pregnant

Signed Date

Radiographer Details

Radiation Dose/DAP:

No. images/projections:

Screening Time:

Signature:

Contrast Injection (complete if required)

Glaucoma Y / N Myeloma Y / N

Renal failure Y / N Diabetic Y / N

Creatinine: eGFR:

Mandatory/Clinical Questions and Responses below:

Does the patient have a cardiac pacemaker? Y / N Does the patient have a neurostimulator? Y / N

Does the patient have a neuro aneurysm clip? Y / N Does the patient have a cochlea implant? Y / N

Does the patient have a programmable hydrocephalus shunt? Y / N

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Oaks Hospital
Part of Ramsay Health Care