Radiology Referral Form

Patient Information

Hospital No. DOB

Surname

Forename

Address

Post Code Tel.

Permission to call/leave message Y / N

Appointment

Date

Time

Date of previous imaging

Walking	☐		
Wheelchair	☐	Portable	☐
Bed/Trolley	☐	Theatre	☐
In Patient	☐	Out Patient	☐

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:	

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Rivers Hospital
Part of Ramsay Health Care