

**Appointment**

Date:

Time:

Date of previous imaging:

The Yorkshire Clinic  
 Bradford Road, Bingley, West Yorks, BD16 1TW  
 Tel: 01274 550 600



**Ramsay**  
 Health Care

**Radiology Referral Form**

**The Ionising Radiation (Medical Exposure) Regulations (IRMER) 2017 requires you to complete all the information. Incomplete or illegible forms will be returned.**

<b>Patient Information</b> Hospital No. <span style="float: right;">DOB</span> Surname Forename Address  Postcode Tel: Permission to call/leave message Y/N	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient  <input type="checkbox"/> Wheelchair <input type="checkbox"/> Portable <input type="checkbox"/> Bed / Trolley <input type="checkbox"/> Theatre
<b>Examination</b>  Radiologist referred to: Justified by: Authorised by:	<b>Please indicate which examination is required</b> <input type="checkbox"/> CT <input type="checkbox"/> DEXA Scan <input type="checkbox"/> Mammography <input type="checkbox"/> Ultrasound <input type="checkbox"/> X-ray
<b>Clinical Information and Question to be Answered</b>	
<b>Referral Details</b> Referrers Name (Please Print)  Address  Signature Date:	<b>Protocol/Comment</b>  Interpreter Required? Yes/ No (State language) Capacity to Consent? Yes/No
<b>Billing</b> <input type="checkbox"/> NHS <input type="checkbox"/> Self-funding <input type="checkbox"/> Medico legal <input type="checkbox"/> Insured Insurance company:	<b>LMP (if required) Date:</b> <b>I certify that there is no possibility I am pregnant</b> Signature: Date:
<b>Radiographer Details</b> Radiation Dose/DAP: No. exposures: Screening Time: Radiographer Signature: Date:	<b>Required for radiation dose optimisation purposes</b> Patient Height:  Patient Weight: