Diagnostic Imaging Request Form

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HIGHGATE PRIVATE HOSPITAL

NB: the patient must bring the original form unless it is received by imaging directly from referrer

*Mandatory feild

PATIENT DETAILS

Name*: _____

DOB*: _____

Hospital Number: _____

Address*: _____

_____

_____

Postcode: _____

Phone: _____

Email: _____

Male ☐ Female ☐

Start date of last menstrual period *(if applicable)*:

_____

Patient Arrival: Trolley ☐ Wheelchair ☐ Walking ☐

Funding: NHS ☐ Self Funded ☐ Insured ☐

Patients insurance company: _____

Membership number: _____

Pre-authorisation number *(if known)*: _____

Please note: Uninsured patients and patients without pre-authorisation are required to pay on the day of their appointment.

MRI ☐ CT ☐ X-ray ☐ Ultrasound ☐

INVESTIGATION REQUIRED:*

Prefered Radiologist *(if applicable)*:

_____

CLINICAL HISTORY:*

Please include blood test results & copies of any previous imaging & reports.

Creatinine Level _____ eGfr _____ Date of blood test _____

INVESTIGATION

Could the patient be pregnant?	YES ☐	NO ☐
Is the patient breast feeding?	YES ☐	NO ☐
Is the patient a high infection risk?	YES ☐	NO ☐
If yes, please specify _____		
Is the patient diabetic?	YES ☐	NO ☐
Is the diabetes controlled by? Diet ☐	Tablet ☐	Insulin ☐
Is the patient on Metformin?	YES ☐	NO ☐
Does the patient have any allergies?	YES ☐	NO ☐
If yes, please specify _____		

TO BE COMPLETED FOR ALL MRI EXAMINATIONS

MRI Contraindications – does the patient have:

A pacemaker?	YES ☐	NO ☐
A cerebral aneurysm clip?	YES ☐	NO ☐
Cochlear implants?	YES ☐	NO ☐
Neurostimulators?	YES ☐	NO ☐
Programmable hydrocephalus shunt?	YES ☐	NO ☐
History of working with metal?	YES ☐	NO ☐
Metallic foreign body in eye?	YES ☐	NO ☐
Other metallic implants?	YES ☐	NO ☐

NB: If YES to any of the above please inform Imaging Department prior to examination

REFERRING CLINICIAN'S DETAILS – IR(ME)R 2018

regulations require this form to be signed by the referring clinician

Consultant name*: _____

Signature*: _____

Date*: _____

Address*: _____

_____

Tel*: _____

Fax*: _____

Email*: _____

FOR RADIOGRAPHER USE ONLY: Comments:

Exposure dose: _____ No of Exposures: _____ Authorisation: _____