Spire
Portsmouth Hospital

Imaging request

CT	☐	MRI	☐
X-ray	☐	Ultra sound	☐

Patient details:

Surname:

First name:

Hosp number: | Dob:

Address:

Town:

Postcode:

Contact details:

	Preferred
Home:	☐
Mobile:	☐
Work:	☐

Email:

Please be aware that standard email is not secure or confidential

Examination requested:

Date requested:

Urgent / Routine / Specify:

Previous relevant radiology and location:

Nature	Date	Location

Clinical information and clinical question:

Question to be addressed: | PTO for diagram: ☐

Specific radiologist requested:

Special requirements:

Mobility: Yes ☐ No ☐ | Communication: Yes ☐ No ☐

Elevated BMI:

Other:

Other information:

Blood tests:

(For CT & MRI scan with contrast the following blood tests are required within a year of the examination.):

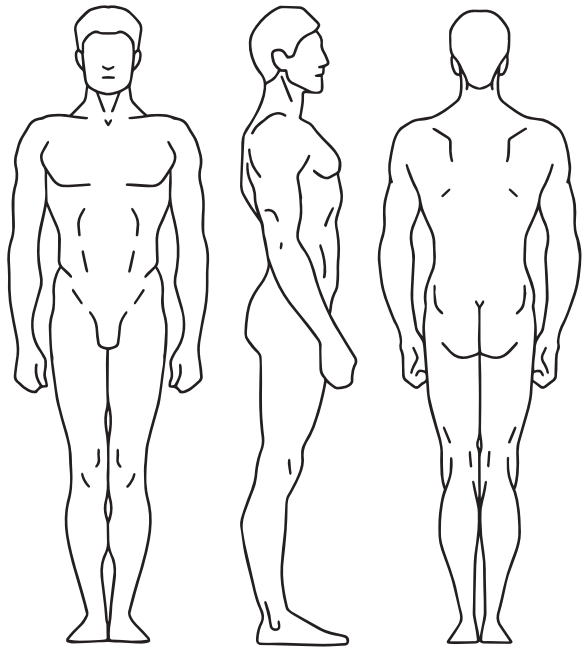
eGFR:	Creatine:
Date:	Location:

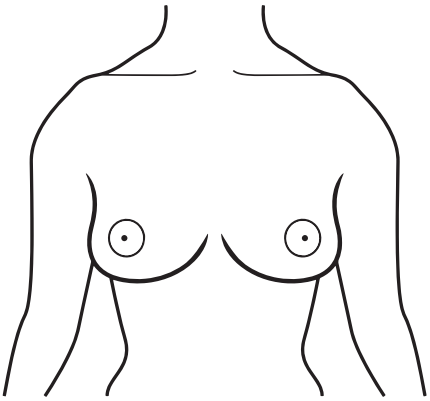
LMP:

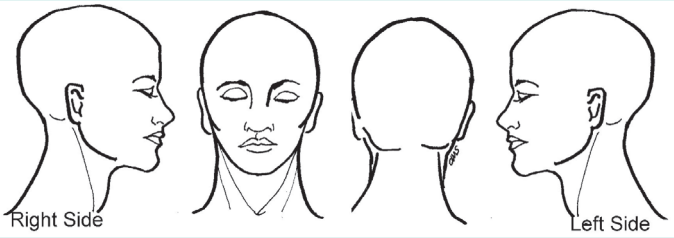
Referring clinician: | Signature:

Address for reports: | Date:

Please indicate position of lesion:







CT Colonoscopy

Scans will not be performed if not completed in full by the referrer.
Has a rectal exam been performed? Yes ☐ No ☐

Does the patient have:

Any known allergies?

Any known contraindications to Gastrografin?

Any known contraindications to Buscopan?

Consultant Signature:

Date:

Additional comments:

For radiology department use

For self funding patients please provide a quote before booking an appointment