Imaging Referral

Appt:

Methley Park Hospital

Methley Lane
Methley
LEEDS LS26 9HG
Tel: 01977 664 209
Fax: 01977 664 232

Ward Room No:	IP ☐ OP ☐

SAP'd ☐ Booked ☐ Q ☐ CC ☐

Title:	Surname:
First Names:	
M ☐ F ☐	Date of Birth:

SAP Number:

Examination Required:

Modality: **XR** ☐ **US** ☐ **CT** ☐ **MRI** ☐ **Nuc Med** ☐

Body Area:

Patient Consent: ☐

Address:

Affix Patient Label Here

Post Code:

Telephone Numbers:

Home:
Mobile:

Clinical Information:

LMP Date:
OR
Sign ……..Date…….
To the best of my knowledge I am not pregnant

Latex Allergy? ☐ Yes ☐ No

Additional Information:

Specific Radiologist required:

Radiographer: Is this request Justified? Yes ☐ No ☐

Has recent Imaging History been estabilised? Yes ☐ No ☐

Referring Clinician:

Address for report:

Signature:

Date: ……

Bowel Preparation: Please sign to confirm that the referred patient is suitable for laxative bowel preparation.

Sign: ……

FOR HOSPITAL USE: PP'd: ☐ Scanned: ☐ Charged: ☐

Projections	Images/Exp's	kV	mAs	Dose	Radiographer	Date	Drug:
							Amount:
							Batch: