

Imaging Referral

Appt:

Unit No. Episode No.

Examination required

Clinical information

Specific radiologist required

Referring clinician

Address for report / films

Signature

Date / /

Title Surname

First Names

Address / Room No.

IP OP

Postcode

Telephone number(s)

Home

Work

Male Female Date of birth

LMP Date

OR

Sign Date / /

To the best of my knowledge I am not pregnant

Additional Information

FOR HOSPITAL USE

No. of films	No. of exp.	Fluoro time / factors	Dose Gy / cm ²	Radiographer	Date	Equipment
Drug		Amount	Batch No.		Administered by	