

# Imaging Referral

Appt date:

Time:

Unit No.  Episode No.

Examination required

Clinical information

Patient under 18 years old? Yes  No

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 <sup>2</sup>	Radiographer	Date	Equipment
Drug		Amount	Batch No.		Administered by	