Imaging Referral Form

Appt:

N.B. This form is a legal document
Please ensure at least three unique patient identifiers have been provided.

Patient details

Patient name	Date of birth
Patient Hospital No:	Referrer Name (Printed):
Patient address	Practice Name/Hospital Name/Ward
Telephone/Mobile Number:	Specific Radiologist Request:

Examination(s) requested:

Clinical Indication/Reason for request:

Referrer's Signature:	Date:

Referrer's Declaration

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- The correct patient details/identifiers have been provided.
- I have given sufficient clinical information for the request to be justified according to the Ionising Radiation (Medical Exposure) Regulations (2000).

Examinations CANNOT be performed without sufficient relevant clinical information and a valid referrer's signature, in line with the Ionising Radiation (Medical Exposure) Regulations (2000).

Imaging Department Use Only:

Radiographer 3-point ID check confirmed and PAUSED (Signature):

Pregnancy status:

I confirm to the best of my knowledge that I am not pregnant:

Patient Signature:.....

Date:.....

Insurance Company

Policy number:

.....

Authorisation code:

.....

Appointment Details

Entered on SAP [ ]

Date.....

Time .....

Spire
London East Hospital

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FOR HOSPITAL USE ONLY:

No. of Films	No. of exp.	Fluoro time/factors	Dose GY/cm²	Radiographer	Date	Equipment

Drug	Amount	Batch No.	Administered by

Sim Code	Area	Quantity	Price	Radiologist	Posted by

Please fax the completed referral form to 0208 709 7877 or send by secure email to roradmin@spirehealthcare.com
If you have any queries please call 0208 709 7878