



Appt:

Imaging referral

| | | |
|----------------------------|-----|----|
| Clinically urgent referral | Yes | No |
|----------------------------|-----|----|

Spire Hospital number:

Examination required:

Clinical information:

Any previous imaging undertaken relating to this referral?
If 'yes' please provide details ie Spire etc: Yes No

Specific radiologist required:

Referring clinician:

Address for report/films:

Title: Surname:

First names:

Address/Room number IP OP

Postcode:

Telephone number(s)

Home: Work:

Male Female Date of birth:

Is a language interpreter required? Yes No

If yes, which language is required?

LMP date:

OR
Sign: Date:

To the best of my knowledge I am not pregnant

Additional information/implant information:

Sign: Date:

Referrer's declaration Please tick and complete the following

| | | | | |
|--|-----------|------|---------|-------|
| Under IRMER 2017 legislation, Referrers have the following responsibilities: – To ensure the patient details are correct – To discuss the procedure with the patient/guardian – To take into account the possibility of pregnancy – To provide sufficient clinical information for the request to be justified by the radiology department – To ensure the radiology report is reviewed | Insurer: | C&B | NHS | SF |
| | ID check: | Name | Address | D.O.B |

| MRI / CT contraindications | Please tick and complete the following | |
|--|--|----|
| Do you have a cardiac pacemaker or other cardiac device? | Yes | No |
| Do you have an internal hearing device? | Yes | No |
| Do you have any other type of electronic implant? | Yes | No |
| Have you ever had metal enter your eyes or body? | Yes | No |
| If 'yes' to any of the above please provide details: | | |
| | | |
| Are you pregnant? | Yes | No |
| Height: | Weight: | |
| eGFR is required for ALL patients over 65 years and any patient with renal impairment receiving contrast in both MRI and CT. | | |
| Result: | Date obtained: | |

| For hospital use | | | | | | |
|------------------|------------|-------------------------|------------|--------------|-----------------|-----------|
| No. of films | No. of exp | Fluoro time/ factors | Dose Gy/m2 | Radiographer | Date | Equipment |
| | | | | | | |
| Drug | | Amount | Batch No. | | Administered by | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| Sim code | Area | Quantity | Price | Radiologist | Posted by | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

Please ensure this imaging request is signed by a doctor prior to submitting to Spire, to prevent any delays