Spire
Little Aston Hospital

Spire Little Aston Hospital
Little Aston Hall Drive
Little Aston
Sutton Coldfield
West Midlands
B74 3UP

Imaging referral

X-ray/Ultrasound Tel: 0121 580 7141
MRI/CT Tel: 0121 580 7129
Email: spirelittleastondiagnosticimaging@spirehealthcare.com

Patient details	
Title:	Hospital/SAP number:
Forename:	Surname:
Sex at birth: Male ☐ Female ☐	Date of birth:
Address: Postcode:	
Mobile Number:	E-mail address:
Examination Requested: Specific Radiologist requested:	
Clinical Indications: (please summarise relevant history, clinical findings and test results) If you require access to i-Refer, please contact the imaging department	
N.B. This is a legal document – Referrer Declaration. As an entitled referrer, I confirm the correct patient details have been provided. I have discussed the examination, including any intervention with the patient and/or guardian, and I have considered the possibility of pregnancy. I have given sufficient clinical information for the request to be justified according to the Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (if applicable)	
Referrer Name:	Referrer Signature:
GMC/HCPC Number:	Date:

CT and MRI requests:	
Cardiac Pacemaker/ICD	Yes ☐ No ☐
Electronic implanted devices	Yes ☐ No ☐
Intracranial aneurysm clips	Yes ☐ No ☐
Cochlear Implant	Yes ☐ No ☐
Metallic implants/fragments	Yes ☐ No ☐
Previous reaction to Contrast Agents	Yes ☐ No ☐
Kidney disease/transplant	Yes ☐ No ☐
eGFR (if known)	ml/min/1.73m² Date:

Imaging referral – Imaging department use

Operator paused checks:	tor Initials:
Patient name	
Date of birth	
Address	
Body part +/- laterality	
Previous imaging	
Correct modality	
Risks discussed with patient/guardian	
Pregnancy checks complete	

Patient consent	
I confirm that I have discussed the risks and benefits of the exposure to radiation, there is no possibility of pregnancy, and I agree to proceed with the examination.	
Patient Signature:	Date:
Operator/Radiographer Signature:	Date:

Justification/authorisation information:
☐ Authorised by (Operator): or ☐ Justified by (Practitioner):

Additional information
Patient transport: Walking ☐ Wheelchair ☐ Bed ☐
Interpreter required: Yes ☐ No ☐ Details:
Any other special needs or assistance or required? : Yes ☐ No ☐ Details:
Book scan for week commencing:
Result of scan required by:
Specific Radiologist required:
Payor Type: SP ☐ PMI ☐ NHS ☐ Other ☐

Looking after you.