Spire Healthcare

# Imaging referral

Please send Imaging referral forms to:
spireharpendendiagnosticimaging@spirehealthcare.com

| Patient details | |
|---|---|
| Title: | Hospital/SAP number: |
| Forename: | Surname: |
| Sex at birth: Male ☐ Female ☐ | Date of birth: |
| Address:<br><br>Postcode: | |
| Mobile Number: | E-mail address: |
| Examination Requested:<br><br>Specific Radiologist requested: | |
| Clinical Indications: (please summarise relevant history, clinical findings and test results)<br><br>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: |

| 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: Or Result of scan required by: |
| Payor Type (please circle) : Self Pay PMI NHS Other |

# Imaging referral – Imaging department use

| Operator paused checks: | Operator 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):

**Booking information**

Specific Radiologist required\performing:

Interpreter required: Yes ☐ language: Interpreter Confirmed: Yes ☐

Any other special needs or assistance or required? : Yes ☐ No ☐ Details:

All Equipment & Drugs available ☐

If self-funding price confirmed ☐

Previous imaging required ☐

Appointment confirmed via E-mail ☐ Text message ☐

Looking after you.