Diagnostic Imaging Request Form

- The Ionising (Medical Exposure) regulations 2017 require you to complete all information accurately.
- Illegible/incomplete forms may be returned
- All fields marked with a * are mandatory
- All forms must be signed by the referring GP, Consultant or Practitioner

Patient Number:			
Patient First Name(s)*		Patient Date of Birth*	
Patient Surname*		Patient Email Address#	
Patient Address and postcode*		Patient Contact Number(s)*	
Patient's GP Name*		Patient's GP Surgery*	
Patient Height	Patient Weight	Patient Gender	Female LMP
Patient Disability	Self-Pay or Insured*	Patient Follow Up Date	

Referrer Name	Referrer Practice
Referrer Role	Referrer Specialty
Referrer contact details	Preferred Radiologist

X-Ray	U/S	MRI	CT	Area for Investigation

Clinical Information*		
	Appointment date and time:	

For MRI patients only:			
Do you have a cardiac pacemaker?	Y/ N	Do you have/have you had any metal fragments in your eyes?	Y/ N
Do you have any heart valve replacements?	Y/ N	Do you have/have you had any brain surgery?	Y/ N
Have you any metal implants in your body?	Y/ N	Are you diabetic?	Y/ N
Do you have kidney or Liver problems?	Y/ N	Do you have allergies?	Y/ N

Referrer signature*	Date	Designation

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One Hatfield to complete:

IR(ME)R Checklist			
Pre-Examination Check	Initials	Pre-Examination Check	Initials
Previous imaging (6 ID check)		Body Part (4 ID check)	
As per Justification		Left/Right (4 ID check)	
Justified by whom?		Protocol/ Clinical Information (5 ID check)	
Patient name (1 ID check)		Pregnancy check	
Address (2 ID check)		DRL check	
D.O.B (3 ID check)			

Radiographer (Authorised by)	Radiographer (Operator)

Room		Date	

Time in	
Time out	

kV/mAs:

Dose (cGycm2):

Number of exposures:

Protocol/Drugs		
Name		Date
Signature		

Patient Holding Record: I understand that by accompanying this patient for their x-ray, I will receive a small radiation dose not greater than approximately 2 weeks of natural background radiation. The radiographer will supply a protective lead apron

Carer	Signature	FFD	Patient to carer distance	Patient dose

Patient Charges:

Self-Pay/Insured	Insurance provider	Self-pay price quoted	Quoted by/ Date