DIAGNOSTIC IMAGING REQUEST FORM

PATIENT NUMBER:

- The Ionising (Medical Exposure) Regulations 2017 require you to provide all information accurately.
- If there is any possibility that the Patient is pregnant they should **not** be referred for a CT, MRI or XR
- Illegible/incomplete forms may be returned
- All fields marked with an asterisk (*) are mandatory
- All forms must be signed by the referring GP, Consultant or Practitioner

Official Use	
Spreadsheet	☐
Completed	☐
Scanned	☐ Pre ☐ Post
Reported	☐
Billed	☐
Paid – Self P	☐

PATIENT DETAILS*/ OHH OPD LABEL:

SURNAME	**FORENAMES**
Date of Birth (DD-MM-YYYY)	
NHS Number (10 digits)	
ADDRESS (must include Postcode)	

Contact number/s	
Email	
NHS/Self Pay/Insured/ Staff/Other (Circle/tick as appropriate)	**Name of Insurer (if insured):** **Membership number:** **Authorisation code:** **(must be provided in advance of imaging/procedure)**
Patient's GP Name	
Patient's GP Surgery	
Preferred Radiologist (if applicable)	

X-RAY	US	MRI+	CT	Fluoro	**Area for Investigation***
☐	☐	☐	☐	☐	

Clinical Information and any special needs*	Appointment Date: Appointment Time:

+Please ask patient to complete MRI safety questions overleaf

CLINICIAN MAKING REFERRAL (Please print name, sign, date, and include contact number. If a consultant please state speciality):

one Hatfield Hospital

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PATIENT NUMBER:

MRI patients only: Do you have or had			
cardiac pacemaker/ replaced heart valves?	Y/ N	Diabetes?	Y/ N
aneurysm clips, coils or shunts inserted?	Y/ N	kidney or liver problems?	Y/ N
other heart operation?	Y/ N	any allergies?	Y/ N
any head or brain surgery?	Y/ N	hearing aid/s, metal dentures or skin patches?	Y/ N
any metal fragments in your eyes?	Y/ N	metallic ink tattoos or body piercings?	Y/ N
any metal implants, joint replacements or other devices in your body?	Y/ N	recent (last 8 weeks) procedure?	Y/ N
		pregnant or breast feeding?	Y/ N

OFFICIAL USE:

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?		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) [sign and date]	**Radiographer (Operator)) [sign and date]**

kV / mAs		**Dose (cGycm2)**		**No. 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 (less than approximately 2 weeks of natural background radiation). The radiographer will supply me with a protective lead apron

Carer	Signature	FFD	Pt to carer distance	Patient dose

I have read and understood the general information for comforters and carers and give my consent to be present and assist during the x-ray examination. There is no possibility that I may be pregnant.

Lead protective clothing provided ☐ Lead Apron ☐ Thyroid Shield ☐ Gloves ☐