One Hatfield Hospital

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 **only** be referred for a CT, MRI or XR if it is clinically urgent and has been approved by a Radiologist
- 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

First Check ☐
Sent to Protocol ☐
Back from Protocol ☐
Next Day Check ☐
Radiographer Initial

Official Use
Spreadsheet ☐
Completed ☐
Scanned ☐ Pre ☐ Post
Reported ☐
Charging ☐

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 *Please indicate if there is any previous imaging	Appointment Date: Appointment Time:

Signature

OHH RD DI Request Form **02-02-2022**

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PATIENT NUMBER:

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

Charging Information To Be Completed By Radiographer:

Modality	Number of Parts Scanned	Any Comments:
Previous Imaging if available	Patient Consent	Compliant with LDRL

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) Dose (uGycm2)	Theatre X-ray	No. of exposures	

Protocol/Drugs		
Name		**Date**
Signature		

Patients between the ages of 12-55 if having x-rays below the shoulders or above the knees				
Date of last period				
There is no possibility that I might be pregnant		Signature		