RADIOLOGY REQUEST FORM

Bupa CROMWELL HOSPITAL

Radiology dept telephone 020 7460 5746/5747 | Radiology dept fax 020 7835 2496/020 7460 5576

PLEASE BRING THIS FORM WITH YOU WHEN YOU ATTEND THE HOSPITAL
All sections of this form must be fully completed

Appointment:

Date _____ Time _____

Referring Consultant / GP _____

Report / Films to _____

Patient details: Place sticker here

Name _____

DOB _____

MRN _____ Sex [M] [F]

Pregnant [Y] [N]

LMP _____ Signature _____

PATIENT TO BRING PREVIOUS X-RAYS OR SCANS

Chg. No	Tick	Exam
633270		HSG
633243		BARIUM F/THROUGH
633240		BARIUM SWALLOW
633246		BARIUM ENEMA
633242		BARIUM MEAL
633160		RIBS
633136		CHEST PA
633137		CHEST PA & LAT
633140		ABDOMEN
633161		ABDO TRANSIT STUDY
633110		SKULL
633103		OPG
633114		PARANASAL SINUSES
633117		FACIAL BONES
633150		CERVICAL SPINE
633151		CERVICAL OBLIQ
633154		DORSAL SPINE
633155		LUMBAR SPINE
633168		TOTAL SPINE
633193		BOTH WRISTS
633487		RIGHT WRIST
633498		LEFT WRIST
633488		RT SCAPHOID VIEW
633499		LT SCAPHOID VIEW
633440		BOTH THUMBS
633441		LEFT THUMB
633442		RIGHT THUMB
633194		BOTH HANDS
633483		RIGHT HAND
633494		LEFT HAND
633191		BOTH ELBOW
633479		RIGHT ELBOW
633490		LEFT ELBOW
633148		BOTH HUMERI
633495		LEFT HUMERUS
633484		RIGHT HUMERUS
633192		BOTH FOREARM
633482		RIGHT FOREARM
633493		LEFT FOREARM

Chg. No	Tick	Exam
633165		PELVIS
633429		RIGHT HIP
633411		LEFT HIP
633199		BOTH FEET
633410		LEFT FOOT
633428		RIGHT FOOT
631005		LFAC FOOT SERIES
633196		BOTH KNEES
633412		LEFT KNEE AP+LAT
633430		RIGHT KNEE AP+LAT
638037		BOTH KNEES SKYLINE
638038		BOTH KNEES INTERCON
633433		RIGHT TALUS & CALC
633439		LEFT TALUS & CALC
633198		BOTH ANKLES
633419		RIGHT ANKLE AP+LAT
633408		LEFT ANKLE AP+LAT
631006		LFAC ANKLE SERIES
633195		BOTH FEMORA
633409		LEFT FEMUR
633427		RIGHT FEMUR
633197		BOTH TIBIAE
633415		LEFT TIBIA & FIBULA
633434		RIGHT TIBIA & FIBULA
633650		LEG LENGTH MEASUREMENT
633190		BOTH SHOULDERS
633497		LEFT SHOULDER
633486		RIGHT SHOULDER
633478		RIGHT CLAVICLE
633489		LEFT CLAVICLE
633203		URODYNAMIC STUDY
621013		BONE DENSITY
639999		INTERPRETATION
621000		MAMMO BILATERAL
621116		MAMMO - LEFT UNILAT
621113		MAMMO - RIGHT UNILAT
621114		MAMMO - RT EXTRA VIEW
621117		MAMMO - LT EXTRA VIEW

Radiation Dose _____ Gy* cm^2

Sec. _____

Special Instructions:
Allergies/Infection Status?

3C's Checklist for Radiographer
(please initial when checked)

- [ ] Correct Patient _____
- [ ] Correct Side _____
- [ ] Correct Procedure _____

CLINICAL INDICATION:
What clinical question do you require answering?

Examinations CANNOT be performed without sufficient relevant clinical information and a Doctor's signature, in line with the Ionising Radiation (Medical Exposures) Regulations 2000.

OTHER EXAMINATIONS OR SPECIAL VIEWS REQUIRED:

Referring Clinical Signature

Signature _____

Date _____

Authorised by _____

Date _____

Operator _____

Date _____

Guidance Notes for Referrers

In accordance with the Ionising Radiation (Medical Exposures) Regulation 2000, the Bupa Cromwell Hospital Radiology Department would like to make all Referrers aware of the following Guidelines:

Referrals:

- A request for a Radiological Examination will be regarded as a request from one Clinician or Health Professional to the Radiology Department for an opinion based upon a radiological examination to assist in the management of a clinical problem.
- Diagnostic Imaging or radiological procedures will only be performed upon a written request signed by a Registered Medical or Dental Practitioner or by an authorised Non-Medical Practitioner.
- Signed referrals (request form or letter) must precede or accompany the patient. Signed faxes are also accepted.
- All requests must carry sufficient information to identify the patient. This normally consists of first name, middle name if any, and family name, date of birth and address.
- All requests must carry sufficient clinical information to enable the requested examination to be justified. Referral criteria are based on the Royal College of Radiologists' Guidelines - "Making the best use of a Department of Clinical Radiology: Guidelines for Doctors".
- All requests shall clearly state the examination requested.
- All requests must include contact details of the Referring Clinician including address and telephone number.

Females of Childbearing Age (12-55 years)

- All requests for X-ray examinations (between the diaphragm and the knees) for females of childbearing age (12-55 years) must state the date of the first day of the patient's menstrual period.

Clinical Justification of Requests:

- All requests for imaging will be assessed prior to exposure by the appropriate Practitioner for the examination to ensure that they meet with The Royal College of Radiologists' Guidelines and any local Guidelines and that, in their professional judgement, they are clinically justified (Royal College of Radiologists Publication: BCFR(00)5).