CT request form

Cromwell Hospital

Radiology dept telephone: 020 7460 5746/5747
Email: radiologyadminteam@cromwellhospital.com

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

Date_____ Time _____
Referring Consultant _____
Report / Films to _____

Place sticker here
Name _____
DOB _____
MRN _____ Sex M F

Pregnant Y N
LMP Signature

PATIENT TO BRING PREVIOUS X-RAYS OR SCANS

EXAMINATION REQUIRED_____ CHARGE CODE _____
CONTRAST REQUIRED? YES _____ NO _____
PNEUMOCOLON ONLY GASTROGRAFFIN ☐
BISACODYL ☐

Referring Clinician Declaration:

Is the patient? :-	Y N	
Diabetic	☐ ☐	eGFR ☐
If diabetic are they on Metformin?	☐ ☐	Creatinine ☐

Patients or referrers who wish to discuss any aspects of their examination including the above contraindications or sedation should contact the CT department. GA: **Please be advised that special arrangements need to be made for all GA and paediatric patients.** Please phone the CT department directly to schedule as well as filling out this request form.

CLINICAL INDICATION / HISTORY AND REASON FOR EXAM:
What clinical question do you require answering?

Special Instructions:
Allergies/Infection Status?

3C's Checklist for Radiographer
(please initial when checked)
☐ Correct Patient
☐ Correct Site
☐ Correct Procedure

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

Protocoled by / No _____ Date _____

IR(ME)R Practitioner _____ Date _____

Operator _____Date _____

Dose _____

Referring Clinician Signature

Signature _____ Date _____

Print name _____

CT request form

Cromwell Hospital

Guidance Notes for Referrers

In accordance with the Ionising Radiation (Medical Exposures) Regulations, the 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.

Patients of Child bearing potential

- All requests for X-ray examinations for patients of childbearing potential 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).