Vascular ultrasound 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

Monday: 2-4.30pm
Tuesday: 2-4.30pm
Wednesday: 2-5.30pm
Thursday: 9-11.30am
Friday: 9-11.30am

Patient details: Place sticker here

Name _____

DOB _____

MRN _____ Sex M F

Appointment:

Date _____ Time _____

Referring Consultant / GP _____

Report / Films to _____

PLEASE GIVE THIS FORM TO OUTPATIENTS BEFORE GOING TO VASCULAR LAB

SPECIAL INSTRUCTIONS:

Is the patient infectious? Yes No (circle as applicable)

If yes, infectious status: _____

Allergies: _____

HEP B Status _____

MRSA Status _____

Chg. No	Tick	Exam		
638010		Ankle Pressure		
638008		Aortic Duplex ***STARVE		
638025		Aneurysm Duplex ***STARVE		
638026		AV Fistula / Access Duplex	R	L
638004		Cartoid Duplex Scan		
638009		Exercise Pressure Test		
638011		False Aneurysm	R	L
638007		Graft Surveillance ***STARVE	R	L
638003		Lower Limb Arterial Duplex Bilateral ***STARVE		
638032		Lower Limb Arterial Duplex Unilateral ***STARVE	R	L
638035		Lower Limb Venous Duplex unilateral	R	L
638002		Lower Limb Venous Duplex bilateral		
638001		Pre-Op Vein Marking	R	L
638006		Upper Limb Arterial Duplex	R	L
638005		Upper Limb Venous Duplex	R	L
639015		Guidance Venous Ablation Unilateral	R	L
639016		Guidance Venous Ablation Bilateral		
638012		EMERGENCY CALL OUT x 1		
638020		EMERGENCY CALL OUT x 2		

***STARVE:	Nothing to eat or drink 4 hours prior to exam, medications can be taken with small amount of still water

CLINICAL HISTORY and reason for exam:
(Past medical or surgical information)

Referring Clinician Signature

Signature:

Date:

Operator:

Date:

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Guidance Notes for Referrers

In accordance with the Ionising Radiation (Medical Exposures) Regulation 2000, 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).