Nuclear medicine request form

Cromwell Hospital

Nuclear Medicine dept telephone 020 7460 5745 | Nuclear Medicine dept email: pet.ct@cromwellhospital.com

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 / CD 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
633526		BONE SCAN WHOLE BODY
638015		BONE SCAN + SPECT
631118		BONE SCAN + SPECT/CT
638039		I-123 DaTscan
638024		GASTRIC EMPTYING
633511		99mTc DTPA GFR
633265		GI BLEED SCAN
633576		HIDA SCAN
639012		I-123 WHOLE BODY SCAN
638888		INDIRECT CYSTOGRAM
633505		I-131 WHOLE BODY SCAN
631028		LACRIMAL SCINTIGRAPHY
639900		LUNG SCAN - VENTILATION & PERFUSION
638031		Lu-177 LUTETIUM THERAPY SCAN
639907		LYMPHOSCINTIGRAPHY
633503		MECKELS DIVERTICULUM
633581		I-123 MIBG INJECTION & SCAN
638018		MUGA SCAN
638022		MYOCARDIAL PERF. SCAN PHARMACOLOGICAL
633591		PARATHYROID SCAN
638023		POST IODINE ABLATION THERAPY SCAN
633592		Se-75 SeHCAT - BILE ACID ABSORPTION
633515		RENAL SCAN - DYNAMIC MAG3 with diuretic
633534		RENAL SCAN - STATIC DMSA
633709		SENTINAL NODE IMAGING
633713		SENTINEL NODE INJECTION ONLY
631245		THYROGEN I-123 SCAN
631024		THYROGEN I-131 SCAN
633500		THYROID SCAN Tc-99m

OTHER EXAMINATIONS BEING REQUESTED AT THE SAME TIME:

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 IRMER.

Referring clinician signature

Signature _____

Date: / /

(Nuclear Medicine dept use only)

IR(ME)R Practitioner _____ Date_____
(under ARSAC)

Operator _____ Date_____

Pharmaceutical _____ Isotope _____

MBq _____ @_____

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Guidance Notes for Referrers

In accordance with the Ionising Radiation (Medical Exposures) Regulation IRMER, 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 electronic copies 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).