

Radiology request form

Cromwell
Hospital

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PLEASE NOTE:

THIS FORM IS VALID FOR 3 MONTHS. PLEASE BRING THIS FORM WITH YOU WHEN YOU ATTEND THE HOSPITAL.
ALL SECTIONS OF THIS FORM MUST BE FULLY COMPLETED FAILURE TO DO SO MAY RESULT IN EXAMINATIONS NOT BEING PERFORMED.

Patient details: (or place sticker here)

Name:

DOB:

MRN:

All sections of this form must be fully completed.

Pregnant: Y N			LMP:			Report to:		
Date:			PT Signature:			To be completed by the referring clinician		
Chg. No	Tick	Exam	Chg. No	Tick	Exam	CLINICAL INDICATION:		
633136		CHEST PA	633433		RIGHT TALUS & CALC	What clinical question do you require answering?		
633137		CHEST PA & LAT	633439		LEFT TALUS & CALC			
633140		ABDOMEN	633198		BOTH ANKLES			
633161		TRANSIT STUDY	633419		RIGHT ANKLE AP+LAT			
633110		SKULL	633408		LEFT ANKLE AP+LAT			
633114		PARANASAL SINUSES	631006		LFAC ANKLE SERIES			
633117		FACIAL BONES	633195		BOTH FEMORA			
633150		CERVICAL SPINE	633427		RIGHT FEMUR			
633154		THORACIC SPINE	633409		LEFT FEMUR			
633155		LUMBAR SPINE	633197		BOTH TIBIAE			
633168		TOTAL SPINE	633434		RIGHT TIBIA & FIBULA			
633193		BOTH WRISTS	633415		LEFT TIBIA & FIBULA			
633487		RIGHT WRIST	633650		LEG LENGTH			
633498		LEFT WRIST	633190		BOTH SHOULDERS			
633488		RT SCAPHOID VIEW	633486		RIGHT SHOULDER			
633499		LT SCAPHOID VIEW	633497		LEFT SHOULDER			
633440		BOTH THUMBS	633478		RIGHT CLAVICLE			
633442		RIGHT THUMB	633489		LEFT CLAVICLE			
633441		LEFT THUMB	639999		INTERPRETATION			
633194		BOTH HANDS	FLUOROSCOPY					
633483		RIGHT HAND	633270		HSG	Examinations CANNOT be performed without sufficient relevant clinical information and a Doctor's signature, in line with the Ionising Radiation (Medical Exposures) Regulations.		
633494		LEFT HAND	633243		BARIUM F/THROUGH			
633191		BOTH ELBOWS	633240		BARIUM SWALLOW			
633479		RIGHT ELBOW	633246		BARIUM ENEMA			
633490		LEFT ELBOW	633242		BARIUM MEAL	OTHER EXAMINATIONS OR VIEWS REQUIRED:		
633484		RIGHT HUMERUS	635620		MOD BARIUM SWALLOW			
633495		LEFT HUMERUS	633203		URODYNAMIC STUDY			
633192		BOTH FOREARM	DEXA					
633482		RIGHT FOREARM	621013		BONE DENSITY			
633493		LEFT FOREARM	639926		BODY COMPOSITION			
633165		PELVIS	THEATRES					
633429		RIGHT HIP	633400		THEATRE IMAGING			
633411		LEFT HIP	DENTAL IMAGING					
633199		BOTH FEET	633103		OPG			
633428		RIGHT FOOT	636659		CBCT DENTAL IMPLANT	REFERRING CLINICIAN SIGNATURE:		
633410		LEFT FOOT	636660		CBCT TOOTH			
631005		LFAC FOOT SERIES	636661		CBCT TMJ			
633196		BOTH KNEES	636662		CBCT SINUSES			
633430		RIGHT KNEE AP+LAT	636667		CBCT MANDIBLE	Name: _____		
633412		LEFT KNEE AP+LAT	636669		CBCT FACIAL BONES	Signature: _____ Date: _____		
638037		BILAT SKYLINE	636670		CBCT ORBIT	GMC/GDC		
633432		Right Knee Skyline						
633414		Left Knee Skyline						
638038		BILAT INTERCON						

To be completed by radiographer

☐ Previous imaging _____	☐ Correct Side	Radiation Dose: _____	Gy* m
☐ Correct Patient	☐ Correct Procedure	Fluoro Time: _____	Operator: _____
Date: _____			

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