Ultrasound request form

Cromwell Hospital

Radiology dept telephone 0207 460 5746 Radiologyadminteam@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
635613		US ABDOMEN
631007		US ABDOMEN ARFI
633626		US ABDOMEN & / DOPPLER
633617		US ABDOMEN & PELVIS
633641		US BIOPSY (HISTOLOGY NOT INCLUDED)
633624		US DRAINAGE (HISTOLOGY NOT INCLUDED)
633274		US RENAL BIOPSY (HISTOLOGY NOT INCLUDED)
635612		US THORAX
633705		US DYNAMIC PENILE DOPPLER
633621		US BREAST BILATERAL
631116		US TRU CUT BIOPSY (HISTOLOGY NOT INCLUDED)
633436		US RIGHT BREAST
633417		US LEFT BREAST
634002		BREAST NON WIRE LUMP LOCALISATION (SAVIS-COUT) (XR937)
634003		BREAST LUMP LOCALISATION (XR936)
631033		US MUSCULOSKELETAL - 1 PART
631045		US MUSCULOSKELETAL - 2 PART
633694		US STEROID INJECTION
633613		US TV (TRANSVAGINAL)
633616		US PELVIC FULL
633618		US RENAL
635241		US RENAL TRACT
635614		US RENAL TRACT & FLOWRATE
631019		US RESIDUAL URINE
631020		US RESIDUAL URINE & FLOWRATE
633382		US FLOWRATE ONLY
633138		US BILATERAL LEG DOPPLER
631016		US FNA (HISTOLOGY NOT INCLUDED)
635611		US THYROID
633620		US SOFT TISSUE
633625		US TR (TRANSRECTAL)
633629		US PROSTATIC BIOPSY (HISTOLOGY NOT INCLUDED)
633703		US PAEDIATRIC CRANIAL
633704		US PAEDIATRIC HIP
063967		US PLATELET RICH PLASMA INJECTION

SPECIAL INSTRUCTIONS:

Allergies _____

Hep B status _____

MRSA status _____

OTHER EXAMINATIONS OR SPECIAL VIEWS REQUIRED:

CLINICAL INDICATION:

What clinical question do you require answering?

Examinations CANNOT be performed without sufficient relevant clinical information and a Doctor's signature.

Referring clinician signature

Signature _____ Date / /

Print name _____

Operator _____ Date / /

Print Name _____

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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 must be justified 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).