Radiology request form

London Medical | Part of Bupa

London Medical: 49 Marylebone High Street, London, W1U 5HJ Email: appointmentsteam@londonmedical.co.uk

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

Appointment:

Date_____ Time_____

Referring Consultant / GP _____

Report / Films to _____

Patient details: Place sticker here

Name _____

DOB _____

MRN_____ Sex M F

Pregnant Y N

LMP_____Signature _____

London Medical Site

Chg. No	Tick	Exam
LMED		US CHEST
		US ABDOMEN & PELVIS
		US UPPER ABDOMEN
		US RENAL TRACT & BLADDER
		US HEAD & VENTRICLE
		US HIP NEONATE
		US SMALL PART
		US PELVIS (GYNAE)
		US RENAL WITH DOPPLER US EXTREMITY 1 PART
		US COLOUR DOPPLER 1 AREA
		US COLOUR DOPPLER 1 AREA
		US GUIDED TRU CUT BIOPSY
		US GUIDED FINE NEEDLE ASPIRATION
		MAMMO BILATERAL
		MAMMO-LT UNILAT
		MAMMO-RT UNILAT
		TOMOSYNTHEISIS BILAT
		TOMOSYNTHEISIS RT
		TOMOSYNTHEISIS LT
		FIBROSCAN

Cromwell Site

Chg. No	Tick	Exam
		Breast Left Lump Localisation
		Vacuum Ass Breast Excision Biopsy (XR121)
		Nuclear medicine Sentinel Node Imaging
		Nuclear medicine Sentinel Node Injection Only
		PETCT Full Body
		PETCT Half Body

Radiation Dose_____Gy* cm^2

Sec. _____

Special Instructions:
Allergies/Infection Status?

Checklist for Radiologist
(please initial when checked)

- ☐ Correct Patient _____
- ☐ Correct Side _____
- ☐ Correct Procedure _____

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.

Radiology request form

London Medical

Part of Bupa

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.

Females of Childbearing Age (12-55 years)

- All requests for X-ray examinations for females of childbearing age (12-55 years) 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).

Fibroscan (only):

- Alcohol consumption
- PMHx:
- Metabolic risk factors (T2DM, Thyroid disease; Hyperlipidaemia)
- Cardiovascular risk factors
- Relevant medication (including those known to precipitate fibrosis e.g Methotrexate)