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
633136		CHEST PA
633137		CHEST PA & LAT
633140		ABDOMEN
633161		TRANSIT STUDY
633110		SKULL
633114		PARANASAL SINUSES
633117		FACIAL BONES
633150		CERVICAL SPINE
633154		THORACIC SPINE
633155		LUMBAR SPINE
633168		TOTAL SPINE
633193		BOTH WRISTS
633487		RIGHT WRIST
633498		LEFT WRIST
633488		RT SCAPHOID VIEW
633499		LT SCAPHOID VIEW
633440		BOTH THUMBS
633442		RIGHT THUMB
633441		LEFT THUMB
633194		BOTH HANDS
633483		RIGHT HAND
633494		LEFT HAND
633191		BOTH ELBOWS
633479		RIGHT ELBOW
633490		LEFT ELBOW
633484		RIGHT HUMERUS
633495		LEFT HUMERUS
633192		BOTH FOREARM
633482		RIGHT FOREARM
633493		LEFT FOREARM
633165		PELVIS
633429		RIGHT HIP
633411		LEFT HIP
633199		BOTH FEET
633428		RIGHT FOOT
633410		LEFT FOOT
631005		LFAC FOOT SERIES
633196		BOTH KNEES
633430		RIGHT KNEE AP+LAT
633412		LEFT KNEE AP+LAT
638037		BILAT SKYLINE
633432		Right Knee Skyline
633414		Left Knee Skyline
638038		BILAT INTERCON

Chg. No	Tick	Exam
633433		RIGHT TALUS & CALC
633439		LEFT TALUS & CALC
633198		BOTH ANKLES
633419		RIGHT ANKLE AP+LAT
633408		LEFT ANKLE AP+LAT
631006		LFAC ANKLE SERIES
633195		BOTH FEMORA
633427		RIGHT FEMUR
633409		LEFT FEMUR
633197		BOTH TIBIAE
633434		RIGHT TIBIA & FIBULA
633415		LEFT TIBIA & FIBULA
633650		LEG LENGTH
633190		BOTH SHOULDERS
633486		RIGHT SHOULDER
633497		LEFT SHOULDER
633478		RIGHT CLAVICLE
633489		LEFT CLAVICLE
639999		INTERPRETATION
FLUOROSCOPY		
633270		HSG
633243		BARIUM F/THROUGH
633240		BARIUM SWALLOW
633246		BARIUM ENEMA
633242		BARIUM MEAL
635620		MOD BARIUM SWALLOW
633203		URODYNAMIC STUDY
DEXA		
621013		BONE DENSITY
639926		BODY COMPOSITION
THEATRES		
633400		THEATRE IMAGING
DENTAL IMAGING		
633103		OPG
636659		CBCT DENTAL IMPLANT
636660		CBCT TOOTH
636661		CBCT TMJ
636662		CBCT SINUSES
636667		CBCT MANDIBLE
636669		CBCT FACIAL BONES
636670		CBCT ORBIT

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.

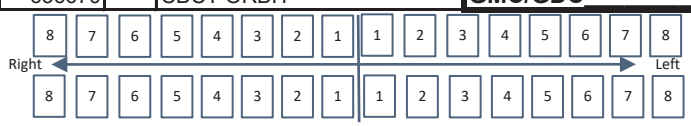
OTHER EXAMINATIONS OR VIEWS REQUIRED:

REFERRING CLINICIAN SIGNATURE:

Name:_____

Signature:_____ **Date:**_____

GMC/GDC_____



Admin Stamp

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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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.
- It is mandated under the IRMER regulations that all requests must cite 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).

Access to iRefer

- iRefer is the essential radiological investigation guidelines tool from the Royal College of Radiologists (RCR) which helps referrers determine the most appropriate imaging investigation or intervention for patients. Access to iRefer and more information on referral processes is available to all IR(ME)R Referrers making requests to the Cromwell Hospital visit: https://www.irefer.org.uk/to find out more information.
- If you would like access, please contact: pet.ct@cromwellhospital.com