

Imaging Request Form

Patient Name/Label:		Date of Birth:	
Address:		Home Number:	
Postcode:		Work/Mobile No.:	
ID/NHS:			
Examination Requested <i>if available</i> <input type="checkbox"/> X-Ray <input type="checkbox"/> Ultrasound <input type="checkbox"/> MRI <i>(please see declaration for contra indications)</i>		Body part to be imaged Clinical Details <i>Including surgery and any medication:</i>	
If contrast is required please provide the following information: Creatinine Level: Date of Test: <input type="checkbox"/> CT (Available off site by discussion)			

Referrer's Declaration.

- 1) The correct patient details have been entered.
- 2) To the best of my knowledge this patient does not have any absolute contra-indications to MRI (e.g. cardiac pacemaker, pacing wire, aneurysm clips, cochlear implant, IOFB).
- 3) I have given sufficient clinical information for the request to be justified according to IR(ME)R 2000.
- 4) I have taken into account the possibility of pregnancy.
 Ignore LMP Ruling
- 5) I will ensure that the examination result is recorded in the patient's case notes.

Referrer's Signature:

Print Name:

Date:

If applicable, I confirm to the best of my knowledge that I am not pregnant.

Patient's Signature:

I hereby give consent to the above examination and confirm that the examination/procedure has been explained to me.

Patient's Signature:

Date:

Operator's Signature:

Date:

For Imaging Department Use Only Justification: This procedure has been justified under the terms of the IR(ME)R 2000 Regulations	Exposure Factors	
	mAs:	
Radiologist's or radiographer's signature:	kVp:	
Billing Information (please tick): <input type="checkbox"/> NHS <input type="checkbox"/> Insured <input type="checkbox"/> Self Funding	Dose:	
	Number of Images:	