South Manchester Diagnostics

MEDICAL IMAGING PARTNERSHIP

South Manchester Diagnostics
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Imaging Request Form

The Ionising radiation (Medical Exposure) Regulations 2017 IR(ME)R require you to complete all this information accurately, incomplete / illegible forms may be returned

Surname

First Name

DoB ☐ Male ☐ Female

NHS Number……
Address

Tel Home Tel Work
Tel Mobile

Appointment ……

Date and Time ……

Referrer's name and address (or stamp)

Signature …….. Date ……..

X-Ray ☐ **US** ☐ **MRI** ☐

Examination requested:

Preferred Radiologist

Clinical Information Please include questions to be answered. Include all relevant laboratory results, medications, surgery and previous examinations

Safety Information (to be completed by referring clinician)

All patient's requiring i.v. contrast

Has the patient had a contrast injection before? Yes ☐ No ☐

Does the patient have any allergies? Yes ☐ No ☐

If "Yes" what?……..

Does the patient have asthma? Yes ☐ No ☐

Is the patient a diabetic? Yes ☐ No ☐

Does the patient take Metformin? Yes ☐ No ☐

Does the patient have renal disease? Yes ☐ No ☐

Is the patient likely to have a raised serum creatinine? Yes ☐ No ☐

Additional information for MRI patients

Does the patient have a cardiac pacemaker? Yes ☐ No ☐

Does the patient have heart valve replacements? Yes ☐ No ☐

Has the patient any metal fragments in their eyes? Yes ☐ No ☐

Has the patient had any cranial surgery? Yes ☐ No ☐

Does the patient have any metal in their body? Yes ☐ No ☐

Is the patient on any anti-coagulant? ……

If so state value or provide eGFR ……

Referrer's declaration (NB: This form is a legal document)

- **The correct patient details have been given**
- **I have discussed the examination with the patient/guardian**
- **I have taken into account the possibility of pregnancy**
- **I have given sufficient clinical information for the request to be justified according to IR(ME)R 2000**
- **I will ensure that the examination results are recorded in the patient's notes**
- **There are no known contra-indications to performing the requested examination/treatment**

Radiologist's protocol:

Operator comments:

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For Completion by Imaging Staff	Examination Justified by: Name and Signature
Person making the exposure has checked the patient's ID YES ☐ NO ☐	Operator's name & signature:
Operator Use **Room**	Number of exposures:
kV mAs dose kV mAs: dose kV: mAs dose kV mAs dose	**To be completed for female patients** **Do you think you may be pregnant? YES □NO □** **If Yes: X-ray now □ Wait for next LMP □** **1st day of LMP (date) ……..** **Are you breast feeding? Yes □ No □** **Signature …….. Date ……**

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:*

Patient chaperone / holding record

I understand that by accompanying this patient for their X-ray examination I will receive a small radiation dose not greater than approximately 2 weeks of natural background radiation. The radiographer will supply a protective lead apron.

Female comforters and carers only – I declare that I am not pregnant	Yes ☐	No ☐

Chaperone / Comforter /Carer Signature:	FFD:	Patient to carer distance:	Patient Dose:

Drugs Administered

Drug	Drug Route	Volume / Dose	Lot Number	Injected By

Patient Charges

Room	Code	Units	Radiologist	Signed

Form returned because: