



RADIOLOGY REQUEST FORM

NOT for USC referrals – please use USC ONLY form
Inappropriate use of referral forms will be audited

The next line below for Radiology use only				
RADIS No		RECEIVED		APPOINTMENT
PATIENT DETAILS ID CHECK (RADIOLOGY STAFF)			CONSULTANT	GP Name
WARD/DEPT or SURGERY				
Surname: Hosp No:				
Forenames:				
Address:		SPECIAL CONSIDERATIONS (please tick box)		
		Disability <input type="checkbox"/>		
		Specify.....		
		Diabetic <input type="checkbox"/> Metformin <input type="checkbox"/>		
		Asthmatic <input type="checkbox"/> Allergies <input type="checkbox"/>		
		Specify		
Post Code:		NHS No		
Date of Birth:				
Home Tel:		Mobile Tel:		
IS PATIENT PREGNANT?	YES/ NO	LMP:	OBSERVE/IGNORE L.M.P. RULE:	
WALK <input type="checkbox"/> CHAIR <input type="checkbox"/> BED <input type="checkbox"/> STRETCHER <input type="checkbox"/> AMBULANCE <input type="checkbox"/>				
EXAMINATIONS REQUIRED		REFERRER DETAILS		
		NAME (PRINT PLEASE) :		BLEEP:
		STATUS: SHO/Staff/Reg/ASp/Cons/GP/NP/Dentist/Other		EXT No:
		SIGNATURE:		DATE
PREVIOUS EXAMINATION		CLINICAL QUESTION		
CLINICAL DETAILS: Legal requirement under IR(ME)R to provide sufficient and correct information				
BMI				
eGFR (contrast studies only)				
Attention is drawn to the RCR Guidelines for the criteria against which this request will be considered.				
FOR RADIOLOGY USE ONLY - DO NOT WRITE BELOW THIS LINE				
PROTOCOL(S)		AUTHORISED BY:	DATE:	
RADIS BARCODE		RADIOGRAPHER COMMENTS		
OPERATOR SIGNATURES	DATE OF EXAM	No IMAGES	No EXPOSURES	DOSE
				cGy.cm ²

NB: INCOMPLETE OR ILLEGIBLE FORMS MAY RESULT IN DELAY OR REFUSAL OF REQUEST