GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

RADIOLOGY REQUEST FORM

USC referral only

INAPPROPRIATE USE OF THIS FORM WILL BE AUDITED

USC

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:

Post Code:
Date of Birth:
Home Tel: Mobile Tel:

SPECIAL CONSIDERATIONS (please tick box)

Disability ☐
Specify……
Diabetic ☐ **Metformin** ☐
Asthmatic ☐ **Allergies** ☐
Specify……

NHS No

IS PATIENT PREGNANT?	YES/ NO	LMP:	OBSERVE/IGNORE L.M.P. RULE:

WALK ☐ CHAIR ☐ BED ☐ STRETCHER ☐ AMBULANCE ☐

EXAMINATIONS REQUIRED	REFERRER DETAILS	
	NAME (PRINT PLEASE) :	BLEEP: EXT No:
	STATUS: SHO/Staff/Reg/ASp/Cons/GP/NP/Dentist/Other	
	SIGNATURE:	DATE

PREVIOUS EXAMINATION	CLINICAL QUESTION

CLINICAL DETAILS: Legal requirement under IR(ME)R to provide sufficient and correct information

BMI ……..

Serum Creatinine (contrast studies only)

……

USC

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