Radiology Request Form

NHS
Eileanan Siar
Western Isles

Name:

Address:

Male/Female

DOB/CHI

D D M M Y Y / ☐☐☐☐

Consultant/GP:

Ward/OPD/Practice:

Urgent/Routine:

Patient contact no:

TRANSPORT:

Walking

Wheelchair

Bed

Trolley

Portable

GP Practice Stamp:

Does the Patient have any special requirements?

Under IR(ME)R 2017 Referrals will only be accepted from Entitled Referrers. The request for exposure to Ionising Radiation must be 'justified' as being of 'net benefit' to the patient.
Incomplete or illegible forms will be returned to sender.

Clinical summary (Include details of previous imaging):

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Clinical question to be answered:

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Investigation requested:

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PATIENT INFORMATION

Infection risk YES NO

If YES please specify……..……

Pregnant YES NO

Weight if >128kg……...

FOR CT & MRI EXAMINATIONS

Renal function < 3months

Required for patients with known or suspected eGFR <60

Creatinine……...Range……

eGFR……

Date……/……/……..

U+E's taken today ☐

REFERRER DETAILS

Print name……. Speciality……..….

Signature……... Date……/……/……..

Medical Referrer / Non Medical Referrer Copy results to…….

CT CHECKLIST

Previous contrast reaction	YES	NO
Allergies	YES	NO
Severe Asthma	YES	NO
Diabetes	YES	NO
On Metformin	YES	NO

If YES to any of the above, please specify:

Please attach completed MRI safety checklist for all MRI requests

FOR RADIOLOGY USE

Appointments:

Justification Comments:

Practitioner Initials:

Radiology use

PREGNANCY STATUS (Refer to EP8 if necessary)

For females aged 12 to 55

Is there any possibility that you may be pregnant?

YES NO MAYBE

Signature of patient

……..

Date…../…../…… LMP…../…../……

Operator……..

EMERGENCY EXAMINATION

Ignore Pregnancy status YES NO

Referring Consultant…….

Justifying Practitioner……...

RADIOLOGY RETURNED REQUEST

This Radiology request is unjustified for the following reasons:

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Signature……..

CT CHECKLIST - CHECKING THE PUMP

Pump filled by……..

Purged of air YES NO

Pump and contrast checked by 1:
2:

Pump connected by…….

Contrast injected by……..…..

RADIOGRAPHER

ID checked by……...

Operator……

Dose:

POST PROCEDURE

Contrast reaction YES NO

Venflon removed by……..

Injection site checked by…….

NOTES