Imaging Request Form

BMI Three Shires Hospital Tel **01604 885002** Fax **01604 885004**
www.threeshiresimaging.com

P/D/T

Surname:	**Forename:**	**DOB:**	**M/F**
Address:	**Contact Numbers:** Mobile: ..... Home:		
	Insurance Details / Self Funding		
APPOINTMENT:	**In Patient:**	**Out Patient:**	

REFERRERS DECLARATION: (N.B This is a legally binding document)

- I have discussed the examination with the Patient / Guardian.
- The Ionising radiation (medical exposure) regulations 2000 require you to complete all this information accurately giving sufficient clinical information.
- The correct patient details have been given.

WARNING MRI

Does the patient have a pacemaker? Yes / No
Has the patient had any brain surgery? Yes / No
Does the patient have an artificial heart valve? Yes / No
Has the patient got any metal in their body? Yes / No
Has the patient ever had metal fragments in their eyes? Yes / No

PREFERRED REPORTING RADIOLOGIST:

EXAMINATION REQUIRED X-Ray U/S MRI

CLINICIAN INFORMATION

Referring Clinician.....Signature.....Date.....

FOR CLINIC USE ONLY

Radiographer has checked the patient's ID. YES NO

Operator use

Dose (total).....uGysq.m Number of Exposures.....

Authorised.....Operator's name & signature.....Date.....

LMP date ..... Or to the best of my knowledge I am not pregnant

Signature ..... **Date** .....

FOR OFFICE USE ONLY	**NHS No:**	**Procedure**	**Code**
MRN.....	**U/G No:** ...../.....		
Accession.....	**Invoiced**.....		
DRUG ADMINISTERED			

DATE	DRUG	VOLUME / DOSE	EXPIRY DATE	BATCH / LOT NO.	DOCTORS SIGNATURE