BMI Healthcare

THE CONSULTANTS' CHOICE

Imaging request

All unshaded sections must be completed by the referrer

The Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) require you to complete all this information accurately. Incomplete/illegible forms may be returned.

Surname ....

First name ....

DoB .... ❑ Male ❑ Female

Hospital number ....

Address ....

....

.... Post code ....

Tel home .... Tel work ....

Tel mobile ....

Appointment ....

Date and Time ....

OP ❑ IP ❑ Room No ....

Oxygen ❑ Disability ....

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 ....

Examination requested:

Pref. Radiologist:

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

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

Referrer's name and address (or stamp)

Signature .... Date ....

Name / Address

Safety information (to be completed by referring clinician)

All patients requiring i.v. contrast.

Question	Yes	No
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 on any anti-coagulant?	Yes ❑	No ❑

Additional information for MRI patients

Question	Yes	No
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 likely to have a raised serum creatinine? ....

If so state value or provide eGFR ....

This form has been returned because:

For completion by Imaging Department staff

Radiologist's protocol:

Person making exposure has checked the patient's I.D. Yes ❑ No ❑

Operator use

Patient's height:

Patient's weight:

kV:

mAs:

Dose (cGycm²)

Fluoro. Time:

Number of exposures / films

Examination justified by: Name & Signature

Date of Justification:

Operator's name & signature

Date of Examination:

Patient 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 ❑

Comforter/Carer	Signature	FFD	Patient to carer distance	Patient dose

Drugs administered

Drugs administered	Drug route	Volume/Dose	Exp. date	Lot no.	Injected by

Radiopharmaceutical prescription			**Prepared by:**				**Admission**	
Nuclide	Compound	Max Activity	Stock No	Dose	Recount	Net	Time	Initial
				MBq				
		Mbq		Time				
				MBq				
		Mbq		Time				

Other medication	**Dose given**	**Batch No.**	**Administered by**	**Prescribers signature**

Patient charges				
Department	Code	Units	Radiologist	Changes

Operator's comments