IMAGING@THREE SHIRES HOSPITAL

BMI Three Shires Hospital
- Part of Circle Health Group -

IMAGING REQUEST FORM P/D/T

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

Surname:	Forename:	DOB:	Male Female
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

	Y	N		Y	N
Does the patient have a pacemaker?			Has the patient had any brain surgery?		
Does the patient have an artificial heart valve?			Has the patient got any metal in their body?		
Has the patient ever had metal fragments in their eyes?					

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

Does (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

MRN:	NHS No:	Prodcedure:	Code:
Accession:	U/G No:		
Invoiced:			

DRUG ADMINISTERED

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