the lister hospital

CHELSEA
OUTPATIENT CENTRE

280 kings road

Imaging Request Form

PLEASE FAX COMPLETED FORM TO +44 (0)20 7349 3893

FOR IMAGING USE ONLY

PATIENT NAME .....

DOB ..... PATIENT NO. **X**.....

ADDRESS .....

.....

TEL NO. .....

IMAGING APPOINTMENT

DATE ...../...../..... TIME .....

REFERRING DOCTOR .....

ADDRESS FOR RESULTS .....

TEL: ..... FAX: .....

NEXT APPOINTMENT WITH Dr .....

EXAMINATION(S) REQUIRED

CLINICAL INDICATION
What clinical question do you require answering?

DOCTOR'S SIGNATURE ..... DATE ...../...../.....
Examinations can **not** be performed without sufficient relevant clinical information and a doctor's signature in line with the Ionising Radiation (Medical Exposures) Regulations 2000

FOR FEMALES (12-55 YRS)
Could you be pregnant? ☐ NO ☐ YES

SIGNED..... DATE ...../...../..... DATE OF LMP ...../...../.....

MRI
Does the patient have any of the following contraindictions? (Please tick)

- ☐ HISTORY OF INTRAORBITAL FB
- ☐ INTRACRANIAL CLIPS
- ☐ PACEMAKER
- ☐ PROSTHETIC HEART VALVE
- ☐ PREGNANCY

IV CONTRAST (Iodine or Gadolinium)
Patients may need to have their Renal Function measured prior to administration of IV contrast. We may only administer IV contrast to patients where their Renal Function has a calculated eGFR above 30mL/min/m^2

Please confirm that IV Contrast can be administered to your patient.

☐ NO ☐ YES

DR'S SIGNATURE ..... DATE ...../...../.....

JUSTIFIED BY:

RADIOGRAPHER:

DATE:

PROTOCOLED BY:

BARIUM ENEMAS, MRI BOWEL STUDIES & CT PNEUMOCOLON EXAMINATIONS

We routinely administer Kleanprep or Picolax bowel preparation for these examinations.

Please confirm that it is suitable for this patient.

☐ NO ☐ YES

DR'S SIGNATURE ..... DATE ...../...../.....

Guidance Notes for Referrers

Chelsea Outpatient Centre Imaging Department would like all referrers to be aware of the following guidelines that are in accordance with the **Ionising Radiation (Medical Exposures) Regulations 2000.**

Referrals:

- A request for a radiological examination will be regarded as a request from one clinician or health professional to the Radiology Department for an opinion based upon a radiological examination to assist in the management of a clinical problem.

- Diagnostic imaging or radiological procedures will only be performed upon a written request signed by a registered medical or dental practitioner or by an authorised non-medical practitioner.

- Referrals (request form or letter) must precede or accompany the patient. Faxes are accepted.

- All requests must carry sufficient information to identify the patient. This normally consists of first name, middle name if any, and family name, date of birth and address.

- All requests must carry sufficient clinical information to enable the requested examination to be justified. Referral criteria are based on the Royal College of Radiologists' Guidelines – 'Making the best use of a Department of Clinical Radiology: Guidelines for Doctors'

- All requests shall clearly state the examination requested

- All requests must include contact details of the referring clinician including address and telephone number

Females of Childbearing Age (12 – 55 years)

- All requests for x-ray examinations (between the diaphragm and the knees) for females of childbearing age (12-55yrs) must state the date of the first day of the patient's menstrual period.

Clinical Justification of Requests

- All requests for imaging will be assessed prior to exposure by the appropriate practitioner for the examination to ensure that they meet with the Royal College of Radiologists' Guidelines and any local guidelines and that, in their professional judgement, they are clinically justified *(Royal College of Radiologist Publication: BFCR (00)5.)*

Please fax completed form to +44 (0)20 7349 3893