Hampden Radiology Tel. 01494 411248 Fax. 01494 372121 info@hampdenradiology.co.uk www.hampdenradiology.co.uk

Hampden Radiology | intelligent imaging

RADIOLOGY REFERRAL FORM

The Ionising Radiation (Medical Exposure) Regulations 2000 require you to complete this information accurately. Incomplete or illegible forms may be returned.

Patient Details (affix label if available)

Hospital Number:
NHS Number:

Surname:
Forename:
Date of Birth:
Address:

Post Code:
Telephone Number:

GP Name/ Practice:

Referrer Details

Name:

GMC or HPC No.

Address for Report:

Post Code:
Telephone Number:

Referrer's signature:
Date:

Examination requested:

Self-pay ☐ or Insured ☐

Reasons for Referral /Clinical Details:

Name of Insurance Company:

Policy Number:

Pre-authorization No.

For patients requiring i.v. contrast:

Is there a history of any of the following?

Asthma	Y ☐	N ☐
Diabetes	Y ☐	N ☐
Metformin medication	Y ☐	N ☐
Renal disease	Y ☐	N ☐
Contrast / Iodine allergy	Y ☐	N ☐
Other Allergies	Y ☐	N ☐

If 'yes' what:

For MRI patients:

Does the patient have any of the following?

Cardiac pacemaker	Y ☐	N ☐
Heart valve replacements	Y ☐	N ☐
Metal fragments in the eyes	Y ☐	N ☐
Previous cranial surgery	Y ☐	N ☐
Cochlear or metal implants	Y ☐	N ☐
Any recent surgery	Y ☐	N ☐

To be completed for female patients:

Could you be pregnant? Y ☐ N ☐
Are you breast feeding? Y ☐ N ☐

1st Day of LMP (Date):
Patient's signature:

Ignore LMP Y ☐ N ☐
Authoriser's signature:

When the referral is received, the patient will be phoned to arrange a convenient appointment.

For Completion by Imaging Department Staff

Radiologist's protocol:

Appointment details:

Hospital:

Date: Time:

Initials:

Patient ID Check

(Operator) Date

Operator's Notes (including number of films for evaluation) ☐

Kvp: mAs:

Dose (cGycm2): Screening time:

Operator(s) undertaking exposure:

Contrast Media / Drugs Administered: