Radiology request form

Cromwell Hospital

Radiology dept, Tel: 020 7460 5746
Email: radiologyadminteam@cromwellhospital.com

PLEASE NOTE:
- THIS FORM IS VALID FOR 3 MONTHS. PLEASE BRING THIS FORM WITH YOU WHEN YOU ATTEND THE HOSPITAL.
- ALL SECTIONS OF THIS FORM MUST BE FULLY COMPLETED FAILURE TO DO SO MAY RESULT IN EXAMINATIONS NOT BEING PERFORMED.

Place Sticker Here

Name

DOB

MRN

ADDRESS SEX M ☐ F ☐

Patients Pregnancy Status

Pregnant: **Y / N** (please circle)

LMP: / /

Patient's signature:

Chg. No	Tick	Exam	Chg. No	Tick	Exam
633270		HSG	633199		BOTH FEET
633240		BARIUM SWALLOW	633428		RIGHT FOOT
633246		BARIUM ENEMA	633410		LEFT FOOT
633242		BARIUM MEAL	631005		LFAC FOOT SERIES
635620		MODIFIED BARIUM SWALLOW	633196		BOTH KNEES
633203		URODYNAMIC STUDY	633430		RIGHT KNEE AP+LAT
633136		CHEST PA	633412		LEFT KNEE AP+LAT
633137		CHEST PA & LAT	638037		BOTH KNEES SKYLINE
633140		ABDOMEN	633432		RIGHT KNEE SKYLINE
633161		ABDO TRANSIT STUDY	633414		LEFT KNEE SKYLINE
633110		SKULL	638038		BOTH KNEES INTERCON
633103		OPG	633433		RT TALUS & CALC
633114		SINUSES	633439		LT TALUS & CALC
633117		FACIAL BONES	633198		BOTH ANKLES
633150		CERVICAL SPINE	633419		RIGHT ANKLE AP+LAT
633154		THORACIC SPINE	633408		LEFT ANKLE AP+LAT
633155		LUMBAR SPINE	631006		LFAC ANKLE SERIES
633168		TOTAL SPINE	633195		BOTH FEMORA
633193		BOTH WRISTS	633427		RIGHT FEMUR
633487		RIGHT WRIST	633409		LEFT FEMUR
633498		LEFT WRIST	633197		BOTH TIBIAE
633488		RT SCAPHOID VIEW	633434		RIGHT TIBIA & FIBULA
633499		LT SCAPHOID	633415		LEFT TIBIA & FIBULA
633440		BOTH THUMBS	633650		LEG LENGTH MEASUREMENT
633442		RIGHT THUMB	633190		BOTH SHOULDERS
633441		LEFT THUMB	633486		RIGHT SHOULDER
633194		BOTH HANDS	633497		LEFT SHOULDER
633483		RIGHT HAND	633478		RIGHT CLAVICLE
633494		LEFT HAND	633489		LEFT CLAVICLE
633191		BOTH ELBOWS	621013		BONE DENSITY
633479		RIGHT ELBOW	639999		INTERPRETATION
633490		LEFT ELBOW	633498		BONE AGE
633484		RIGHT HUMERUS	621000		MAMMO BILATERAL
633495		LEFT HUMERUS	621116		MAMMO- LT UNILAT
633192		BOTH FOREARMS	621113		MAMMO- RT UNILAT
633482		RIGHT FOREARM	621009		TOMOSYNTHESIS BILAT
633493		LEFT FOREARM	621008		TOMOSYNTHESIS RT
633165		PELVIS	621007		TOMOSYNTHESIS LT
633429		RIGHT HIP	621125		VACUUM ASSISTED BREAST BIOPSY
633411		LEFT HIP	621127		VACUUM ASSISTED BREAST EXCISION BIOPSY (XR121)

TO BE COMPLETED BY REFERRING CLINICIAN

CLINICAL INDICATION:

What clinical question do you require answering?

Examinations CANNOT be performed without sufficient relevant clinical information and a doctor's signature, in line with the Ionising Radiation (Medical Exposures) Regulations.

OTHER EXAMINATIONS OR SPECIAL VIEWS REQUIRED:

Referring Clinician Signature

Name _____

Signature _____ Date _____

Report to _____

To be completed by Radiographer

Checklist for Radiographer
(please initial when checked)
☐ Previous imaging _____
☐ Correct Patient
☐ Correct Side
☐ Correct Procedure

Radiation Dose_____ dGy* cm2

Sec. _____

Operator: Date:

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Guidance Notes for Referrers

In accordance with the Ionising Radiation (Medical Exposures) Regulations, the Cromwell Hospital Radiology Department would like to make all Referrers aware of the following Guidelines:

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.
- Signed referrals (request form or letter) must precede or accompany the patient. Signed faxes are also accepted.
- It is mandated under the IRMER regulations that all requests must cite 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 for females of childbearing age (12-55 years) 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 Radiologists Publication: BCFR(00)5).

Access to iRefer

- iRefer is the essential radiological investigation guidelines tool from the Royal College of Radiologists (RCR) which helps referrers determine the most appropriate imaging investigation or intervention for patients. Access to iRefer and more information on referral processes is available to all IR(ME)R Referrers making requests to the Cromwell Hospital visit: https://www.irefer.org.uk/to find out more information.
- If you would like access, please contact: pet.ct@cromwellhospital.com