Medical Imaging Request Form

Barnsley Hospital NHS
NHS Foundation Trust

INCOMPLETE OR ILLEGIBLE REQUESTS WILL BE RETURNED TO THE REFERRER

☐ NHS ☐ CAT II ☐ Private

Patient Details

Surname:

First Name(s

Unit No:
D.O.B: **NHS No:**
Address:

Tel No:
Male/Female

Occupation:

Additional Patient Details

Aneurysm Clips in Head Y/N:

Artificial Heart Valve Y/N:
Pacemaker Y/N:
Diabetic Y/N: **On Metformin Y/N:**
Disabilities Y/N:

Allergies:
Recent Surgery:

Creatinine Level & Date:

Urea Level & Date: Serum urea level :

Infection Risk:

Referrer Details

GP:

GP Details/Stamp

Dept. to be informed of measures required prior to patient attendance

Must be completed for females aged 12-55 years
Date of LMP:
EDD: **Signature:**
A negative pregnancy test is required if LMP date is outside specific Dept. protocol (10 or 28 day rule) for the examination request.

Mode of Transport	
☐ Ambulance ☐ Medicar	☐ Walking ☐ Trolley ☐ Wheelchair
☐ Required ☐ Ordered	**Oxygen Required Y/N:** **Manual Handling Risk?:**

Clinical Details/Clinical Questions to be answered

Examination Requested – Including Modality

Referrers Declaration – Mandatory
The correct patient details have been given.
I have discussed the examination with patient/guardian
I have taken into account the possibility of pregnancy
I understand my obligations under IR(ME)R2000

Referrers Name (please print):

Referrers Designation (please print):

Referrers Signature:

Contact No:
Date:

Department Use Only

Radiographer: **Booked out by:**
No. of Images: **Screening Time:**
Dose Area:

Room: **Red Dot:**

Priority	Patient Preparation
1	No Prep
2	Fast
3	Full Bladder

Appointment/Request Card Sticker

MRI/CT/US Protocol
Signature

Contrast/Buscopan Injected by:

Contrast Sticker