

**Imaging Request Form:  
CT, Ultrasound & X-ray**



Please complete all the relevant sections of this request form.  
Completed forms should be faxed to 0870 1304854

Patient Information	Funding
Surname:..... Forename:.....	GP/NHS <input type="checkbox"/> Private Insurance <input type="checkbox"/>
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Self Funded <input type="checkbox"/>
Date of Birth: / /	Patient's Health Insurance Company:
Address:.....	.....
.....	.....
.....	.....
Postcode:.....	Membership Number:
NHS No.....	.....
Telephone:.....	.....
Email Address:.....	.....

Referring Clinician's Details	
Name:	Telephone:
Job Title:	Fax:
Hospital / GP Practice:	Email Address:
Address:	Signature:
Postcode:	Date: / /

Relevant Medical History	
Please include details of any relevant previous imaging and surgery.	Drug Allergies: Could the patient be Pregnant: Yes <input type="checkbox"/> No <input type="checkbox"/> Last Menstrual Period: / / Most recent Creatinine: Date: / / Is the patient diabetic: Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, on Metformin? Yes <input type="checkbox"/> No <input type="checkbox"/> Infection risk? Yes <input type="checkbox"/> No <input type="checkbox"/>

Examination Requested:	CT <input type="checkbox"/> Ultrasound <input type="checkbox"/> X-ray <input type="checkbox"/>
<b>Reason for referral:</b> Please send all relevant previous radiological reports	Body area to be imaged: