9 HARLEY STREET

PHOENIX DIAGNOSTICS IMAGING REQUEST FORM

25 HARLEY STREET

T: 0207 079 2102 F: 0207 079 2103 E: diagnostics@phoenixhospitalgroup.com W: www.phoenixhospitalgroup.com

Patient details (affix label if available)

Title .... Address ....

Name ....

.... Postcode ....

DOB ..../......../........ Male ☐ Female ☐ Self pay ☐ Insured ☐ Third Party ☐

Contact Telephone number (s) .... Insurance Co/Policy number ....

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Examination Details

Date of exam .... Appointment time ....

Patient number ....

Examination/Procedure (please tick most appropriate)

CT ☐ MRI ☐ U/S ☐ X-RAY ☐ DEXA ☐ Preferred radiologist ....

Relevant Clinical Details

Relevant Clinical Details (please tick most appropriate)

MRI

- Cardiac pacemaker, cochlear implant, cerebral aneurysm clips? ☐
- Surgery in the last 8 weeks? ☐
- History of metallic foreign body to eye? ☐
- Possibility of pregnancy/breast feeding? ☐
- Renal impairment? If so we need eGFR before giving contrast ☐
- Does the patient have any implants/foreign bodies in their body e.g. replacement joints, plates, drug pumps, wires, clips or shrapnel? ☐
- Any allergies? (If yes, please state below exactly what) ☐

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CT

- Possibility of pregnancy/breast feeding? ☐
- Renal impairment? If so we need eGFR before giving contrast ☐
- Any history of diabetes? ☐
- Is the patient on metformin or Glucophage? ☐
- Any allergies? (If yes, please state below exactly what) ☐

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DEXA

- Possibility of pregnancy ☐

Ultrasound

- Possibility of pregnancy ☐

Referring clinician's details

Referrer name ....

GMC Number (if applicable) ....

Contact Number ....

Date ....

Email ....

Fax ....

Address ....

....

....

....

How would you like to receive the report (please tick)

Email ☐ Post ☐ Fax ☐

Referrers Declaration

- The correct details have been provided
- I have discussed the examination including any intervention
- I have taken into account the possibility of pregnancy
- I have given sufficient clinical information for the requested to be justified according to IR (ME)R 2000
- There are no known contra-indications to performing the requested examination
- The ionising Radiation (Medical Exposure) Regulations 2000 require you to complete all this information accurately
- I will ensure the examination results are recorded in the patients notes
- I confirm this is my approved signature
- By sending this e-mail, I am signing this referral electronically. I agree that my electronic signature is the legal equivalent of my manual signature on this referral form and has the same validity. I consent to be legally bound by this Agreement's terms and conditions.

Signed ....

Date ....

V2-1018