PHOENIX DIAGNOSTICS
part of **Phoenix Hospital Group**

PHOENIX DIAGNOSTICS IMAGING REQUEST FORM

Patient details (affix label if available)

Title . . . . . Address . . . . .

Name . . . . . .

. . . . . Postcode . . . . .

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

Contact Telephone number (s) . . . . . Location London ☐ Essex ☐

. . . . . Insurance Co/Policy number . . . . .

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 . . . . .

. . . . .

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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 . . . . .

V3 04. 21