PHOENIX DIAGNOSTICS
IMAGING REQUEST FORM

Patient details (affix label if available) - 3 forms of ID required

Title ....

Name ....

....

DOB ..../......../........ Male ☐ Female ☐

Contact Telephone number (s) ....

....

Address ....

....

.... Postcode ....

Self pay ☐ Insured ☐ Third Party ☐

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 ☐ Body Composition

Preferred radiologist ....

Relevant Clinical Details (please include required body area)

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 2017
- There are no known contra-indications to performing the requested examination
- The Ionising Radiation (Medical Exposure) Regulations 2017 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