

RADIOLOGY REQUEST FORM

Queen Mary's Hospital

Roehampton, SW15 5PN

Tel: 020 8487 6512/3
Fax: 020 8487 6178

Surname		First Name		Date of Birth		NHS No.			
Address				Patient Mobility (tick)					
				Walk		Bed			
				Chair		Trolley			
Post Code				Patient Cat. (circle one)					
Tel No				NHS / Private / Cat II					
Examination Requested:									
Clinical Information:						Practice stamp:			
Clinical Question you want answered?									
For Women Aged 12-55:				Practitioner					
LMP		No possibility of pregnancy:		Radiologist:		Pended:			
RAD		Date:		Radiographer:		Appointment			
Initials:				Operator:		Date:			
I have no reason to believe I am pregnant				Dose:		Time:			
Signature:				Fluoro Time/Exposure Factors:					
Date:				No. of images:					
				Office Use Only					