|  |  |  |  |
| --- | --- | --- | --- |
| St George's Universi#4AF260**RADIOLOGY REQUEST FORM**  Contact numbers: 0208 725 3037 (St George’s Hospital 8am-5pm Mon-Fri),  (Times are for walk-in x-rays)  0208 487 6512 (Queen Mary’s Hospital, 8am-7pm Mon-Fri, 11am-4pm Sat, Sun & Bank Holidays),  0203 668 3355 (Nelson Health Centre 9am-5pm Mon-Fri)  Department Email Address: RadiologyDepartment@stgeorges.nhs.uk  0208 812 6571 (St John’s Therapy Centre 9am-4pm Mon-Fri) | | | |
| **Appt:** Date: Time: Room: | | | |
| Surname:  First name:  Hosp. No.:  NHS No.:  Sex: M / F  D.O.B.:  Tel No.: | Patient Address:  G.P. Name & GMC Number:  G.P. Practice Address: | | SIGNATURE (not needed if sent electronically from NHS.net account):  DATE:  **N.B.: Request valid for 8 weeks** |
| ***Complete for all women aged 12-55 who might be pregnant but still require the examination.***  **The pregnancy rule should be ignored*.***  **Doctor’s signature** |
| EXAMINATION REQUESTED: | | | By signing this form I declare that:  1. The correct patient details have been entered  2. I have taken into account the possibility of pregnancy  3. I have given sufficient clinical information for the request to be justified according to IR(ME)R 2017  4. I have discussed this examination with the patient |
| CLINICAL INFORMATION: | | |
| *If the patient is in a clinical trial, you MUST give the trial name and LREC No.:* | | | |
| Is the patient ASTHMATIC? YES NO | | Is this patient a falls risk? YES NO (please put note in clinic information if yes) | |
| ***N.B.: There must be sufficient information provided for the Radiology Department to be able to justify the request under the Ionising Radiation (Medical Exposure) Regulations 2017*** | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **SGH Department of Diagnostic Radiology – DEPARTMENTAL USE ONLY** | | | | | | | |
| Examination Justified: Y / N  Practitioner’s signature: | Images taken (***record total number of each size used, including repeats)*** | | | | | | |
| 18 x 24 |  | 24 x 30 |  | 30 x 40 |  |  |
|  |  |  |  |  |  |  |
| 25 x 35 |  | 35 x 43 |  | 18 x 43 |  |  |
|  |  |  |  |  |  |
| Operator’s Signature: | Other: | | | | | | |
| Radiologist: | DAP reading: | | | | | | |
| Fluoro time / Exposure Factors: | | | | | | |
| Comments: |
| Radionuclide activity:  Date: Time: | | | | | | |
| L.M.P.: |
| I have no reason to believe I am pregnant.  I have had the risks of this examination explained to me.  ***Signed:***  ***Date:*** |