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| 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 / FD.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 entered2. I have taken into account the possibility of pregnancy3. I have given sufficient clinical information for the request to be justified according to IR(ME)R 20174. 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*** |

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| **SGH Department of Diagnostic Radiology – DEPARTMENTAL USE ONLY** |
| Examination Justified: Y / NPractitioner’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:*** |