

AFFIX PATIENT LABEL
HERE

IMAGING REQUEST FORM

THE PRINCESS GRACE HOSPITAL

part of HCAHealthcare uk

Please select facility and forward appropriately

Princess Grace Hospital,
42-52 Nottingham Place, London, W1U 5NY
pgradiology@HCAHealthcare.co.uk
Tel: 0207 908 2000

London Digestive Centre, 41 Welbeck Street London, W1G 8EA
ldcmaging@HCAHealthcare.co.uk
Tel: 02039053915

ISEH, 170 Tottenham Court Road, Fitzrovia, London W1T 7HA
imaging.iseh@hcahealthcare.co.uk
Tel: 0207 908 2000

The London Centre for Orthopaedic Services 30 Devonshire Street, London, W1G 6PU
pgradiology@HCAHealthcare.co.uk (X-Ray & Ultrasound)
Tel: 0207 908 2000
MRI.30Devonshire@HCAHealthcare.co.uk (MRI)
Tel: 02079083741 / 02079083775

PLEASE SEND ALL RELEVANT IMAGING WITH THE PATIENT

<p>Patient name:</p> <p>DoB: . D . D . M . M . Y . Y . Y . Y . . .</p> <p>Hospital No: X</p> <p>Address:</p> <p>Daytime Tel: Mobile:</p> <p>Email:</p> <p>Sex: Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to say <input type="checkbox"/></p> <p>Other(please state)</p> <p>Inpatients</p> <p>Walk <input type="checkbox"/> Chair <input type="checkbox"/> Bed <input type="checkbox"/> Portable <input type="checkbox"/> O2 <input type="checkbox"/></p> <p>Source Isolated <input type="checkbox"/> Room No. <input type="text"/></p>	<p>Referring Doctor:</p> <p>GMC Number:</p> <p>Address for results:</p> <p>Tel:</p> <p>Email:</p> <p>Does this patient have any contraindications to MRI? <input type="checkbox"/> NO <input type="checkbox"/> YES (*if yes please provide further info below)</p> <p>.....</p> <p>.....</p> <p>MRI: Your patient may not be scanned if you do not indicate any contraindications.</p>
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<p>Examination required:</p>	<p>Clinical indication:</p> <p>Examinations cannot be performed without sufficient information in line with the Ionising Radiation (Medical Exposure) Regulations</p>
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<p>Preferred Radiologist:</p> <p>Is patient diabetic? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Is the diabetes controlled by:</p> <p>Diet <input type="checkbox"/> Insulin <input type="checkbox"/> Medication <input type="checkbox"/></p>	<p>Signed by referrer:</p> <p>Date: . D . D . M . M . Y . Y . Y . Y . . .</p>
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RADIOLOGY USE ONLY

<p>Females:</p> <p>LMP Date: . D . D . M . M . Y . Y . Y . Y . . .</p> <p>Could you be pregnant? Yes / No</p> <p>Is the Patient breastfeeding? Yes/ No</p> <p>Signed by patient:</p>	<p>Authorised by:</p> <p>Radiographer:</p> <p>Justified by:</p> <p>Date:</p> <p>Radiation Dose/Time:/.....</p>
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<p>PACS Checked for previous images? YES / NO</p> <p>If Yes, date & type of previous Images: <input type="text" value="SIGN"/></p>	<table border="1" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <p>Bloods</p> <p>Creatinine: Date:</p> <p>Platelets: Date:</p> <p>I.N.R: Date:</p> <p>eGFR: Date:</p> </td> <td style="width: 50%; vertical-align: top;"> <p>Contrast Amount:</p> <p><input type="text" value="STICKER"/> mls</p> <p>Reaction?</p> </td> </tr> </table>	<p>Bloods</p> <p>Creatinine: Date:</p> <p>Platelets: Date:</p> <p>I.N.R: Date:</p> <p>eGFR: Date:</p>	<p>Contrast Amount:</p> <p><input type="text" value="STICKER"/> mls</p> <p>Reaction?</p>
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Duties of the Referrer Under IR(ME)R

The Imaging Department operates in accordance with the requirements of the **Ionising Radiation (Medical Exposure) Regulations (IR(ME)R)**. Therefore your attention is drawn to the following points.

Referrals

- A request for a radiological investigation will be regarded as a request from a registered medical practitioner, dental practitioner or other registered health professional to the Imaging Department for an opinion to assist in the clinical management of a patient.
- Radiological investigations will only be undertaken upon receipt of a written request signed and dated by a registered medical practitioner or other registered health professional who has a referral agreement with the department.
- Referrals, request form or headed letter, must precede or accompany the patient. Faxes are accepted. The request should be clear and legible.
- All requests must have adequate clinical information to justify the examination based on the Royal College of Radiologist's Guidelines - **"iRefer: Making the best use of clinical radiology" [1]**
- All requests must clearly state the modality required to undertake the examination. All requests must be marked with the referrers contact details.

Females of Childbearing age

- For X-Ray examinations between the diaphragm and the knee, all requests must state the date of the first day of the patients last menstrual period.

Clinical Justification of Requests

- Under the IR(ME)R, all imaging requests must be justified by an imaging department practitioner to ensure that there is a net benefit, from the examination, to the patient. Therefore, any requests that are illegible, unsigned or lacking the required information will be returned.

[1] Available from the Imaging Department.

Informed patient consent for paediatric CT scan

Following careful consideration of your child's unique medical needs, this CT examination is the best procedure to answer the clinical question which has been explained to you by your Consultant.

CT examinations are very quick, and are therefore particularly well suited for very young or ill patients who have difficulty remaining still for long periods of time. While there are other imaging examinations that do not use radiation, this particular test will best provide us with the information needed. Although it is desirable to avoid repeated CT scans, the dose of radiation from a CT scan is very low.

I have considered alternative tests and concluded that this is the examination indicated for your child. This imaging facility uses equipment, protocols and techniques suitable for children.

Consultant Signed _____

Patient parent/guardian: _____

