Request for X-Ray

Patient No. _____

WLI No. _____

3fivetwo™ HEALTHCARE

Referrers are required to complete sections 1-4 accurately and legibly. Inadequately completed forms will not be accepted.

1 Patient Details: print or affix addressograph or label

Surname: _____ Forename: _____ Title: _____

Date of Birth: _____ Gender: Male / Female (Delete as appropriate)

Address: _____

_____

Post Code: _____ Tel (Home): _____ Mobile: _____

Patient Identification: For 3fivetwo Healthcare use only.

I have confirmed the above patients name, address and DOB. Signed: _____

Verified by patient: ☐ If another / Status: _____ Signed: _____

2 Cautions (if none, tick here ☐)

Diabetes mellitus: must be completed if patient required to fast prior to procedure OR requires iv/a contrast media)

☐ No If Yes / Controlled by: ☐ Insulin ☐ Glucophage / metformin ☐ Diet ☐ Other / Specify: _____

Other cautions

☐ Blind ☐ Impaired cognitive functioning ☐ Deaf ☐ Other / Specify: _____ ☐ Mobility

Infection risk to staff

☐ MRSA

☐ Category 3

☐ Other

(Specify): _____

_____

3 Clinical Details / Notes: Please include provisional diagnosis or indication and indicate results of previous tests / imaging if applicable.

You are legally obliged under IR(ME)R NI 2000 to supply sufficient medical data for justification purposes.

☐ **LMP/ Pregnancy status:** _____

4

Examination / procedure requested: _____

Referrer (print name): _____ Signature: _____ Date: _____

Address: _____

_____

Post Code: _____ Tel (Home): _____ Mobile: _____

Appointment date & time: _____

For operator / practitioner use only

Examination / procedure authorised by: _____ Date: _____

(subject to a decision to proceed following completion of pregnancy status section on reverse, if relevant)

Please send by post or fax to: **3fivetwo Healthcare** Medical Imaging Centre, 6 Lisburn Road, Belfast BT9 6AA **T** +44 (0)28 9073 5266 **F** +44 (0)28 9024 9929 **E** imaging@3fivetwo.com

XR

Pregnancy Status / This section must be completed for a female aged 12 – 55 years for procedures in which the primary X-ray beam irradiates the area between the diaphragm and upper femora.

For operator / practitioner use only

A

Ascertain from the patient if she is:

- ☐ Definitely not pregnant (Complete B & D and proceed with exposure)
- ☐ Definitely pregnant (Complete B & C)
- ☐ Might be pregnant (Complete B & C)

B

Date of the first day of last menstrual period (LMP) _

_____

C

Practitioner must review justification for the proposed exposure

- ☐ Justified (Complete D and proceed with exposure)

Practitioner's signature: _____

Out of hours: Discussed with: _____

Operator's initials: _____ Date: _____

- ☐ Not justified proceed as follows: _____

D

Patients signature: _____

Operator's initials: _____

Date: _____

Scan reporting & dispatch

Assigned to (Radiologist): _____ ☐ Reported ☐ Report sent

Pharmaceutical prescription & Administration

Name:	Strength:	Dose / quantity:	Batch no. & Expiry date:	Drawn up by:	Checked by:

Prescribers signature:

Administered by:

Examination / Procedure details

Date	Examination	kVp	mAs	DAP reading	Screening time	Number of images	Operator

Notes:

For 352 Admin use: This patient is: ☐ Insured ☐ Self Funding ☐ Waiting List Initiative ☐ Employer ☐ Occ Health / Screen

Insurance Company / Trust: _____

Policy Number: _____ Authorisation Number: _____

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