This form is essential, please retain and bring to your appointment.

Private & Confidential

Hospital of St John & St Elizabeth
160 years of compassion and excellence supporting St John's Hospice

Imaging Department

60 Grove End Road, London, NW8 9NH
Tel: 020 7806 4030 Fax: 020 7806 4002
Email: imagingreception@hje.org.uk
Monday – Friday: 8:00am – 8:00pm

Hospital Number:
Surname:
Forenames:
Date of birth: ___ / ___ / ___ ☐ Male ☐ Female
Address:
Postcode:
Daytime Telephone: Mobile:
☐ Self paying ☐ Insured ☐ Third Party
☐ Appointment

☐ Walking ☐ Chair ☐ Bed / Trolley ☐ Portable ☐ Theatre ☐ Fax Report

Examination Requested – Please see the notes on the reverse of this form.
Please Tick:

☐ X-ray ☐ Mammography ☐ Ultrasound ☐ CT Scan ☐ MRI Scan ☐ Fluoroscopy

Details:

For females between the ages 12 – 55 years Date of LMP: ___ / ___ / ___ Is the patient pregnant? **Y** ☐ **N** ☐
* See notes regarding 28 and 10 day rules Is the patient breast feeding? **Y** ☐ **N** ☐

For I.V.iodine based contrast examinations:
e.g. IVU, CT, Venography, Arteriography
Please indicate if the patient is:

Asthmatic / allergic to contrast?	☐ Yes	☐ No
Diabetic on Metformin?	☐ Yes	☐ No
On Warfarin ?	☐ Yes	☐ No

For MRI examinations: Are there any contraindications for MRI?
☐ Yes ☐ No
History of intra-orbital FB, intra-cranial aneurysm clips, cochlear implants, shrapnel injuries, pacemaker, prosthetic heart valves, bio or neuro stimulators, pain infusion pumps, pregnancy, etc. If Yes, or unsure, please contact MRI for further advice.

Clinical History – Please see the notes on the reverse of this form. If there are films or reports for previous examinations relevant to the present problem, please ensure they accompany the patient.

Signature Of Referring Clinician:	Date Requested:___ / ___ / ___
Name of Referring Clinician: (Please print)	Telephone:
Address for Results:	Fax:
	Mobile:
	Pager:

IMAGING DEPARTMENT USE

Attendance Date: ___ / ___ / ___	Time:	☐ Requested ☐ Traced	Prep: ☐ Hand: ☐ Posted: ☐ Tel:
☐ Walk-in ☐ Pre-booked ☐ Call-out ☐ Previous Films here			

For Interventional Radiology Procedures

Verbal/informal consent obtained Y ☐ N ☐ Procedure explained to patient Y ☐ N ☐ Aftercare leaflet/advice given Y ☐ N ☐

Name: _____ **Signature:**_____

IMAGING DEPARTMENT USE ONLY

Females of Childbearing Age (12 – 55 yrs)– Declaration to be completed by the patient and operator.
Is there any possibility that you might be pregnant? ☐ Yes ☐ No

Signed (Patient): _____ **Date:** ___ / ___ / ___ **Signed (Operator): _____**

Examination Justified & Authorised By: _____

☐ Justified and Authorised by Operator – request complies with departmental guidelines and standard protocols

Room 1 DR Fluoroscopy:	Clinician:	Screening Time:	DAP Reading:	Number of Images:
☐ Room 3: DR	☐ Room 4: DR	☐ CR System	☐ Mammography: DR	

Total number of Digital Exposures:		**DAP Reading:**	
☐ Ultrasound 1:		☐ Ultrasound 2:	
☐ CT Scanning:		Total mAs:	DLP:
☐ MRI:			

☐ Mini C-arm:	☐ Compact II No. 1	☐ Compact II No. 2	☐ Mobilett / CR System

Theatre time in:	Theatre time out:	Screening time:	DAP Reading:	Digital Images:

Contrast Media:	☐ Hand Injection	☐ Power Injection
Contrast:	Vol.	Batch:
Expiry Date:	Checked by:	Administered by:

Operators	
Primary Operator (Name):	Assistant Operator (Name):

Guidance Notes for Referrers

In accordance with the requirements of **Ionising Radiation (Medical Exposures) Regulations 2000**, the referrer's attention is drawn to the following referral protocols in use at the Hospital of St. John & St. Elizabeth.

Referrals:

- Requests for X-ray, Ultrasound or MRI examinations will be regarded as a request from one clinician or health professional to the Imaging Department for an opinion, based upon the X-ray, ultrasound or MRI examination, to assist in the management of a clinical problem. The department does not release unreported films.
- Diagnostic imaging (Ultrasound / MRI / X-ray / CT) and interventional procedures will only be performed upon written request signed by a registered medical or dental practitioner or by an authorised non-medical practitioner.
- Referrals (request form or letter) must precede or accompany the patient. Faxes are accepted.
- All requests must carry sufficient information to identify the patient, normally consisting of first name, middle initial if any, family name, date of birth and address.
- All requests must carry sufficient clinical information to enable the requested examination to be justified. Referral criteria are based on the Royal College of Radiologists' Guidelines – "Making the best use of a Department of Clinical Radiology: Guidelines for Doctors".
- All requests shall clearly state the examination requested.
- All requests must include contact details of the referring clinician including address, telephone and fax numbers.

Females of Childbearing Age (12 – 55 y ears)

- All requests for X-ray examination (between the diaphragm and the knee) of females of childbearing age (12 – 55 years) must state the date of the first day of the patient's last menstrual period.
- The "**10 day rule**" is applied to high dose examinations, e.g. HSG, Barium Enema, IVU, CT Abdomen. The "**28 day rule**" is applied to other x-ray examinations (between the diaphragm and the knee).

Clinical Justification of Requests

- All requests for imaging will be assessed prior to exposure by the appropriate practitioner for the examination to ensure that they meet with the Royal College of Radiologists' Guidelines and any local guidelines and that in their professional judgement they are clinically justified (Royal College of Radiologists Publication: BFCR (00)5).

MRI Examinations

- Patients or their carers will be required to complete a safety questionnaire before the examination commences. The examination will only proceed if the MR Radiographer / Radiologist are satisfied that the patient is not at risk of injury from the MRI scanner.