Imaging Request Form

Patient Name / Label: **Address:** **Postcode:** **ID/NHS:**	**Date of Birth:** **Home Number:** **Work / Mobile No:**

Examination Requested **if available** [ ] X-Ray [ ] Ultrasound [ ] CT [ ] MRI (please see declaration for contra indications) **If contrast is required, please provide the following information:** Creatinine Level: Date of Test:	**Body part to be imaged** **Clinical Details** Including surgery and any medication

Referrer's Declaration.

1. The correct patient details have been entered.	**Referrer's signature:** **Print Name:**
2. To the best of my knowledge this patient does not have any absolute contra-indications to MRI (e.g. cardiac pacemaker pacing wire, aneurysm clips, cochlear implant, IOFB).	
3. I have given sufficient clinical information for the request to be justified according to IR(ME)R 2017	
4. I have taken into account the possibility of pregnancy. [ ] Ignore LMP Ruling	*If applicable, I confirm to the best of my knowledge that I am not pregnant*. **Patient's Signature:**
5. I will ensure that the examination result is recorded in the patient's case notes.	

I hereby give consent to the above examination and confirm that the examination/procedure has been explained to me.

Patient's Signature: ***Date:***	***Operator's Signature:*** ***Date:***

For Imaging Department Use Only **Justification: This procedure has been justified under the terms of the IR(ME)R 2017 Regulations**	**Exposure Factors**	
Radiologist's or radiographer's signature:	**mAs:**	
	kVp:	
Billing Information (please tick): **[ ] NHS [ ] Insured [ ] Self- Funding**	**Dose:**	
	No of images	