

Request for X-Ray

Patient No. _____

WLI No. _____

3fivetwoTM
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: _____

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 9066 4352 F +44 (0)28 9024 9929 E imaging@3fivetwo.com

XR

Assigned to (Radiologist): _____

Reported Report sent Disc sent Date sent

Address sent to: _____

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

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	Number of films

Comments:

Notes:

Angle of LGB to horizontal plane:

Oesophagus shows normal motility:

Size and shape of pouch:

Oesophagus sphincter opens and closes:

For 352 Admin use: This patient is: Insured Self Funding Waiting List Initiative Employer Occ Health / Screen
Insurance Company / Trust: _____

Policy Number: _____ Authorisation Number: _____