Request for CT Scan

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

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 ☐)

At risk of contrast induced nephropathy

Risk factors include renal impairment, diabetes, myeloma, diuretic administration and illness likely to contribute to hypovolaemia.

☐ No If Yes creatinine level ________ µmol/l Date of test: ______________

NB If creatinine≥ 150 µmol/l contrast will not be administered without specific approval of the referring Medical Practitioner.

Approved by: ______________________ Referring Medical Practitioner

Diabetes mellitus

☐ No If Yes / Controlled by: ☐ Insulin ☐ Glucophage / metformin

☐ Diet ☐ Other / Specify: ______________

Other cautions

☐ Blind ☐ Impaired cognitive functioning

☐ Deaf ☐ Other / Specify: ______________

☐ Mobility

Pregnancy Status ☐ Yes ☐ No Date of LMP: __________

Infection risk to staff

☐ MRSA

☐ Category 3

☐ Other (Specify): ______________

Allergy / Asthma

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.

4 Examination / procedure requested: ____

Referrer (print name): ______________________ Signature: ______________________

Address: ____ Post Code: ______________

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

CT

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: ______________________

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	SOP (✓)	DLP	CTDI VOL	Radiologist(s)
					Operator(s)

Scan reporting & dispatch

Assigned to (Radiologist): ______________________ ☐ Report Sent ☐ Disc Sent Date Sent: __________

Address sent to: ____

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: ______________________

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