

# Request for CT Scan

Patient No. \_\_\_\_\_

WLI No. \_\_\_\_\_

**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: \_\_\_\_\_  
Operator undertaking the exposure

## 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 \_\_\_\_\_  $\mu\text{mol/l}$  Date of test: \_\_\_\_\_

NB If creatinine  $\geq 150 \mu\text{mol/l}$  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: \_\_\_\_\_ Date: \_\_\_\_\_

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)

**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: \_\_\_\_\_