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: ____________________

Operator undertaking the exposure

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: ____________________ 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)

Please send by post or fax to: **3fivetwo Healthcare** Medical Imaging Centre, 6 Lisburn Road, Belfast BT9 6AA **T** +44 (0)28 9073 5266 **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 9073 5266 **F** +44 (0)28 9024 9929 **E** imaging@3fivetwo.com

CT