



# Imaging Request Form

BMI Three Shires Hospital Tel 01604 885002 Fax 01604 885004  
[www.threshiresimaging.com](http://www.threshiresimaging.com)

**P/D/T**

<b>Surname:</b>	<b>Forename:</b>	<b>DOB:</b>	<b>M/F</b>
<b>Address:</b>	<b>Contact Numbers:</b> Mobile: ..... Home: .....		
	Insurance Details / Self Funding		
<b>APPOINTMENT:</b>	<b>In Patient:</b>	<b>Out Patient:</b>	
<b>REFERRERS DECLARATION:</b> (N.B This is a legally binding document)			
<ul style="list-style-type: none"> <li>· I have discussed the examination with the Patient / Guardian.</li> <li>· The Ionising radiation (medical exposure) regulations 2000 require you to complete all this information accurately giving sufficient clinical information.</li> <li>· The correct patient details have been given.</li> </ul>			
<b>WARNING MRI</b>			
Does the patient have a pacemaker?	Yes / No	Has the patient had any brain surgery?	Yes / No
Does the patient have an artificial heart valve?	Yes / No	Has the patient got any metal in their body?	Yes / No
Has the patient ever had metal fragments in their eyes? Yes / No			
<b>PREFERRED REPORTING RADIOLOGIST:</b>			
<b>EXAMINATION REQUIRED</b>	X-Ray	U/S	MRI
<b>CLINICIAN INFORMATION</b>			
Referring Clinician.....Signature.....Date.....			
<b>FOR CLINIC USE ONLY</b>			
Radiographer has checked the patient's ID.	YES	NO	
<b>Operator use</b>			
Dose (total).....uGysq.m	Number of Exposures.....		
Authorised.....Operator's name & signature.....Date.....			
LMP date .....	Or to the best of my knowledge I am not pregnant		
<b>Signature</b> .....	<b>Date</b> .....		
<b>FOR OFFICE USE ONLY</b>		<b>Procedure</b>	<b>Code</b>
MRN.....	NHS No: .....		
Accession.....	U/G No: ...../.....		
	Invoiced.....		
<b>DRUG ADMINISTERED</b>			

DATE	DRUG	VOLUME / DOSE	EXPIRY DATE	BATCH / LOT NO.	DOCTORS SIGNATURE