the Radiology Clinic
81 Harborne Road
Tel: 0121-455 9496
Fax: 0121-455 0288
Email: info@theradiologyclinic.co.uk
www.theradiologyclinic.co.uk

Imaging Request Form

PATIENT DETAILS:

Name:

Date of Birth:

Address:

Tel: ……

Mobile: ……..

Email: ……

Male / Female

Patient Mobility: Wheelchair / Walking

REFERRER DETAILS:

Name:

Practice: ……..

Mobile: ……

Email: ……

Report to: ……

Signature:

EXAMINATION REQUIRED:	**RADIOLOGIST**

Clinical Information:- (what clinical question do you require answering?)

Previous imaging Y / N
X Ray / Ultrasound / CT / MRI Dates: Where:

SAFETY CHECKS:

Infection Risk Y / N
Could the patient be pregnant? Y / N
Is patient breast feeding Y / N
Date of last period: ……

Renal function: SCr ……..

Diabetes Y / N Asthmatic Y / N
Pacemaker Y / N Metal Foreign Body Y / N

FUNDING: NHS SELF-PAY INSURED

Insurance Co: ……..

Insurance No: ……..

Pre-Authorisation No: ……

Note: Uninsured patients & patients without pre-authorisation are required to pay on the day of appointment.

OFFICE USE ONLY:

Date of referral: …… Appointment Date: …….. Justified: ……..

Pre Authorisation No: …….. Notes: ……