AFFIX PATIENT LABEL HERE

IMAGING REQUEST FORM

— THE —
HARLEY STREET CLINIC®
part of HCAHealthcare UK

Please select facility and forward appropriately

PLEASE SEND ALL RELEVANT IMAGING WITH THE PATIENT

The Harley Street Clinic,
81 Harley Street, London, W1G 8PP
RadiologyBookings@hcahealthcare.co.uk
Tel: 020 7034 8280 ☐

Chiswick Medical Centre, Bond House
347-353 Chiswick High Road, London, W4 4HS
Chiswick.Imaging@hcahealthcare.co.uk
Tel: 020 3947 4429 ☐

New Malden Outpatients and Diagnostics
171 Clarence Avenue, New Malden, KT3 3TX
nmdc.reception@hcahealthcare.co.uk
Tel: 020 3277 0160 ☐

The Harley Street Clinic Diagnostic Centre
16 Devonshire Street, London, W1G 7AF
RadiologyBookings@hcahealthcare.co.uk
Tel: 020 7034 8280 ☐

Patient name: .....

DoB: D D M M Y Y Y Y

Hospital No: X .....

Address: .....

.....

Daytime Tel: ..... Mobile: .....

Email: .....

Sex: Male ☐ Female ☐ Prefer not to say ☐

Other(please state) ☐ .....

Inpatients

Walk ☐ Chair ☐ Bed ☐ Portable ☐ 02 ☐

Source Isolated ☐ Room No. ☐

Referring Doctor: .....

GMC Number: .....

Address for results: .....

.....

Tel: .....

Email: .....

Does this patient have any contraindications to MRI?

☐ NO ☐ YES (*if yes please provide further info below)

. . . . . .

. . . . . .

MRI: Your patient may not be scanned if you do not indicate any contraindications.

Examination required:

Clinical indication:

Examinations **cannot** be performed without sufficient information in line with the Ionising Radiation (Medical Exposure) Regulations

Preferred Radiologist: .....

Is patient diabetic? Yes ☐ No ☐

Is the diabetes controlled by:

Diet ☐ Insulin ☐ Medication ☐

Signed by referrer: .....

Date: D D M M Y Y Y Y

RADIOLOGY USE ONLY

LMP Date: D D M M Y Y Y Y

Could you be pregnant? Yes / No

Are you breastfeeding? Yes/No

Signed by patient: .....

Authorised by: .....

Radiographer: .....

Justified by: .....

Date: .....

Radiation Dose/Time: ...../.....

PACS Checked for previous images? YES / NO

If Yes, date & type of previous Images:

SIGN

Bloods

Creatinine: Date: .....

Platelets: Date: .....

I.N.R: Date: .....

eGFR: Date: .....

Contrast Amount:

STICKER

mls

Reaction? .....

RAD-REQFRM

Duties of the Referrer Under IR(ME)R

The Imaging Department operates in accordance with the requirements of the **Ionising Radiation (Medical Exposure) Regulations (IR(ME)R)**. Therefore your attention is drawn to the following points.

Referrals

- A request for a radiological investigation will be regarded as a request from a registered medical practitioner, dental practitioner or other registered health professional to the Imaging Department for an opinion to assist in the clinical management of a patient.
- Radiological investigations will only be undertaken upon receipt of a written request signed and dated by a registered medical practitioner or other registered health professional who has a referral agreement with the department.
- Referrals, request form or headed letter, must precede or accompany the patient. Faxes are accepted. The request should be clear and legible.
- All requests must have adequate clinical information to justify the examination based on the Royal College of Radiologist's Guidelines - **"iRefer: Making the best use of clinical radiology"** **[1]**
- All requests must clearly state the modality required to undertake the examination. All requests must be marked with the referrers contact details.

Females of Childbearing age

- For X-Ray examinations between the diaphragm and the knee, all requests must state the date of the first day of the patients last menstrual period.

Clinical Justification of Requests

- Under the IR(ME)R,all imaging requests must be justified by an imaging department practitioner to ensure that there is a net benefit, from the examination, to the patient. Therefore, any requests that are illegible, unsigned or lacking the required information will be returned.

[1] Available from the Imaging Department.

Consultant Signed _____

Patient parent/guardian: _____