Imaging Request Form
FAX: 0845 6171335

Yorkshire Health Solutions
innovation & quality

Patient Name/Label: _____	Home Tel: _____
Address: _____	Mobile Tel: _____
Postcode: _____ Date of Birth: _____	Work Tel: _____
Patient NHS No: _____	E-mail: _____

Examination Requested If Available:

- Ultrasound ☐
- MRI * ☐
- CT ☐
- X Ray ☐
- Other ☐

Creatinine/EGFR: _____
Date of Test: _____

*Please see Declarations for contraindications

Body Part to Be Imaged

Clinical Details
Including any previous surgery and current medication:

Referrer's Declaration.

1. The correct patient details have been entered
2. To the best of my knowledge this patient does not have any absolute contraindications to MRI (e.g. cardiac pacemaker, pacing wire, aneurysm clips, cochlear implant, IOFB).
3. I have given sufficient clinical information to justify the request according to IR(ME)R 2000.
4. I have taken into account the possibility of pregnancy.
5. I will ensure that the examination result will be recorded in the patient notes

Referrer's Signature: _____

Print Name: _____

Date: _____

Referrer Specialty: _____

Referrer's Contact: _____

Address for Report: _____

_____

I hereby give consent to the above examination and confirm that the examination/procedure has been explained to me.

Patient Signature. If applicable I confirm to the best of my knowledge I am not pregnant.	Operator's Signature:
Date:	Date:

Billing Information (please Tick):

☐NHS ☐Insured ☐Self funding

For Imaging department Use Only
Justification: This procedure has been justified under terms of the IR(ME)R 2000 Regulations
Signature (Radiologist or Radiographer)