

# Imaging Request Form



**YORKSHIRE  
HEALTH  
SOLUTIONS**  
innovation & quality

<b>Patient Name/Label:</b> _____  <b>Address:</b> _____  <b>Postcode:</b> _____ <b>Date of Birth:</b> _____  <b>Patient NHS No:</b> _____		<b>Home Tel:</b> _____  <b>Mobile Tel:</b> _____  <b>Work Tel:</b> _____  <b>e-mail:</b> _____
<b>Examination Requested If Available:</b>  Ultrasound <input type="checkbox"/>  MRI * <input type="checkbox"/>  CT <input type="checkbox"/>  X Ray <input type="checkbox"/>  Other <input type="checkbox"/>  Creatinine/EGFR: _____ Date of Test: _____ *Please see Declarations for contraindications	<b>Body Part to Be Imaged</b>  <b>Clinical Details</b> 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.*

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

**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)