



# Radiology Request Form

## Patient Details *Please write clearly and complete in BLACK ink*

PID ..... NHS No .....

Surname ..... Address .....

Forename ..... .....

DOB ..... Sex .....

Preferred Contact No ..... Postcode ..... Operator ID.....

If Label used PRINT patient name in this box

Hospital ..... Consultant .....

Ward / Dept ..... Speciality .....

Patient Category *please tick* NHS  CATII  Private  Clinical Trial

Mobility *please tick* Walk  Chair  Bed  Mobile  Escort

Special Needs *please tick* Sight  Hearing  Interpreter  Oxygen  Barrier

## Procedure or Examination required

## Medical Status

Infection risk .....

Allergies .....

## Clinical Information / Therapy

Clinical Questions & Relevant Information

## Pregnancy

LMP .....

## Breast Feeding

Yes  No

## Exams requiring intravenous contrast

### Renal Function

U&E Test Underway

### Asthmatic

Yes  No

Creatinine Result

### Diabetic

Insulin  Metformin

INR

## MRI *please tick if the patient has the following*

Pacemaker  Aneurysm clips

Metal foreign body  Operation within 3/12

## Referrer's Details (person completing the form)

### *Hospital Referrer*

Referrer's name .....

Title .....

Bleep / Mobile no. ....

### *GP or other non-Hospital referral*

Referrer's name .....

Practice code/occupation .....

Practice Address .....

## Signature .....

Date .....

.....

## Failure to complete correctly will result in the form being returned

**FOR CHEST X-RAYS No Appointment is needed for Chest X-Rays.**  
 Please attend Radiology Department on any weekday (exc. bank holidays)  
**between 9am - 4pm at Heartlands Hospital, Solihull Hospital or Good Hope  
 Hospital (Treatment centre X-ray - Area F)**  
 Alternatively attend xray dept at **Birmingham Chest Clinic on  
 Mon -Thurs 9.15am - 12.15pm / 1.30pm - 4.15pm. Fri 9.15am - 12.15pm.**  
*Patients without an appointment will be dealt with on a first served basis  
 and you may have to wait a short while.*

## FOR OFFICE USE ONLY

Notes