Royal United Hospital NHS Trust

RADIOLOGY REFERRAL FORM

As a Referrer under the Ionising Radiation Medical Exposure Regulations 2000, you are responsible for providing sufficient information to allow for identification of the patient and justification of the examination. If you do not do this, the request will be returned to you.

X-ray 01225 824357/8 X-ray Fax 01225 825515 CT 01225 825989 MRI 01225 824072 U/S 01225 825529 Nuc Med 01225 824076

Patient Details (affix label if available)	Referrer Details	Patient Requirements
RUH No. NHS Number Surname Forename Date of Birth Address Post Code Telephone Number GP Name / Practice	Name Consultant Referrers Signature Date Bleep / Phone Number	Ward O.P. Clinic Known Allergies Special needs: Please Specify ❑ Walking ❑ Chair ❑ Bed ❑ O_2 ❑ Mobile X-ray ❑ NHS ❑ Category II ❑ Research ❑ Medico Legal ❑ PP

Examination Requested: X-ray MRI CT N/M Non Obs U/S Obs U/S (Please Circle)

Suspected Cancer Referral ❑

Cancer Staging Referral ❑

Reasons for Referral / Clinical Details

Clinical Diagnosis _____

How will this affect patient management? _____

Examination Authorised By	Practitioner / Operator	Date
Practitioners Notes Initials _____	Appointment details Booked Admission Date Time Y / N Transport Booked Y / N Initials _____	Appt Letter Sent Date Appt Telephone Date
Patient ID check	(Operator)	Date

Pregnancy Status (refer to department protocol and complete the following)

Patient Pregnant? Maybe / Yes / No LMP Date _____ Patient's Signature _____ Date _____

Examination justified by practitioner Yes / No Authoriser's Signature _____ Operator's Initials _____

Breast Feeding Status Breast Feeding ❑ Not Breast Feeding ❑ Checked by _____

Operators Notes (including number of films for evaluation) ☐

Operator(s) undertaking exposure _____

Contrast Media / Drugs Administered

	Exam	Room	KVp	mAs	Dose / Activity	Screening Time
EXAMINATION PROCEDURE where NOT recorded on RMS immediately						