Bupa Cromwell Hospital

Bupa

Angiography Request Form

Radiology Dept. Direct Line (020) 7460 5746/5747

Radiology Dept. Direct Fax (020) 7835 2496 / (020) 7460 5576

PLEASE BRING THIS FORM WITH YOU WHEN YOU ATTEND THE HOSPITAL
All sections of this form must be fully completed

Appointment

Date _____ Time _____

Referring Consultant / GP _____

Report / CD to: _____

Pregnant : Y / N

LMP _____ Signature _____

Patient Details: Place Sticker Here

Name: _____

DoB: _____

Hospital No: _____ Sex: M F

PATIENT TO BRING PREVIOUS X-RAYS OR SCANS

Tick	Exam
	CAVAGRAM
	DSA ARCH AND NECK
	DSA CARTOID
	DSA CEREBRAL
	DSA CEREBRAL - GAMMA KNIFE
	DSA FEMORAL
	DSA HEPATIC
	HEPATIC/SPLENIC PRESSURE MEASUREMENT
	DSA MESENTERIC
	DSA RENAL
	DSA SPLENIC
	DSA UPPER LIMB
	PERCUTANEOUS CHOLANGIOGRAM
	BILLIARY DRAINAGE/STENT INSERTION
	CAVEL FILTER
	DSA & ANGIOPLASTY
	DSA FEMORAL WITH THROMBOLYSIS
	EMOBOLISATION
	EPIDURAL INJECTION
	FACET JOINT INJECTION
	HEPATIC CHEMO EMBOLISATION
	INSERTION HICKMAN LINE
	NEPHROSTOMY
	NEPHROSTOMY REVIEW
	THOMBOLYSIS REVIEW
	TRANSJUGULAR LIVER BIOPSY
	TRANSHEPATIC PORTAL SYSTEMIC SHUNT (TIPSS)
	T-TUBE CHOLANGIOGRAM
	ULTRASOUND GUIDED LIVER BIOPSY
	VENOUS SAMPLING

Radiation Dose _____ $Gy^{*}cm^{2}$

Fluroscopy Time _____

OTHER EXAMINATIONS OR SPECIAL VIEWS REQUIRED:

Special Instructions

Allergies _____

HEP B Status _____

MRSA Status _____

Other _____

CLINICAL HISTORY & REASON FOR EXAM

Referring Clinician Signature

_____ Date _____

Authorised by: _____ Date _____

Operator(s) : _____ Date _____