# CT REQUEST FORM

Bupa CROMWELL HOSPITAL

CT dept telephone 020 7460 5613 | CT dept fax 020 7835 2493

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 _____

Report / Films to _____

**Patient details:** Place sticker here

Name _____

DOB _____

MRN _____ Sex M F

Pregnant Y N

LMP _____ Signature _____

PATIENT TO BRING PREVIOUS X-RAYS OR SCANS

EXAMINATION REQUIRED _____ CHARGE CODE _____

CONTRAST REQUIRED? YES _____ NO _____

PNEUMOCOLON ONLY GASTROGRAFFIN ☐
BISACODYL ☐

Referring Clinician Declaration:

| | | | |
|---|---|---|---|
| Is the patient? :- | Y N | | |
| Diabetic | ☐ ☐ | eGFR | ☐ |
| If diabetic are they on Glucophage? | ☐ ☐ | Creatinine | ☐ |

CONTRAINDICATIONS TO CONTRAST MEDIA: **ASTHMA, HISTORY OF ALLERGIES, PREVIOUS CONTRAST, END STAGE KIDNEY OR HEART FAILURE, MYELOMA OR SICKLE CELL ANAEMIA.**

Patients or referrers who wish to discuss any aspects of their examination including the above contraindications or sedation should contact the CT department. GA: Please be advised that special arrangements need to be made for all GA and paediatric patients. Please phone the CT department directly to schedule as well as filling out this request form.

CLINICAL INDICATION / HISTORY AND REASON FOR EXAM:
What clinical question do you require answering?

Examinations CANNOT be performed without sufficient relevant clinical information and a Doctor's signature, in line with the Ionising Radiation (Medical Exposures) Regulation 2000.

Protocoled by / No _____ Date _____

IR(ME)R Practitioner _____ Date _____

Operator _____ Date _____

Dose _____

Referring Clinician Signature

Signature _____ Date _____

## Guidance Notes for Referrers

In accordance with the Ionising Radiation (Medical Exposures) Regulation 2000, the Bupa Cromwell Hospital Radiology Department would like to make all Referrers aware of the following Guidelines:

### Referrals:

- A request for a Radiological Examination will be regarded as a request from one Clinician or Health Professional to the Radiology Department for an opinion based upon a radiological examination to assist in the management of a clinical problem.
- Diagnostic Imaging or radiological procedures will only be performed upon a written request signed by a Registered Medical or Dental Practitioner or by an authorised Non-Medical Practitioner.
- Signed referrals (request form or letter) must precede or accompany the patient. Signed faxes are also accepted.
- All requests must carry sufficient information to identify the patient. This normally consists of first name, middle name if any, and family name, date of birth and address.
- All requests must carry sufficient clinical information to enable the requested examination to be justified. Referral criteria are based on the Royal College of Radiologists' Guidelines - "Making the best use of a Department of Clinical Radiology: Guidelines for Doctors".
- All requests shall clearly state the examination requested.
- All requests must include contact details of the Referring Clinician including address and telephone number.

### Females of Childbearing Age (12-55 years)

- All requests for X-ray examinations (between the diaphragm and the knees) for females of childbearing age (12-55 years) must state the date of the first day of the patient's menstrual period.

### Clinical Justification of Requests:

- All requests for imaging will be assessed prior to exposure by the appropriate Practitioner for the examination to ensure that they meet with The Royal College of Radiologists' Guidelines and any local Guidelines and that, in their professional judgement, they are clinically justified (Royal College of Radiologists Publication: BCFR(00)5).