Sports Radiology

RAMSAY

Radiology Referral Form

Patient Information

Hospital No. DOB
Surname
Forename
Address

Post Code Tel.
Permission to call/leave message Y/N

Appointment
Date
Time
Date of Previous Imaging

Walking	☐	Portable	☐
Wheelchair	☐	Theatre	☐
Bed/Trolley	☐		
In Patient	☐	Out Patient	☐

Examination

Radiologist referred to:

Justified by:

Protocol/Comment

Clinical History

Referral Details

Referrers name

Address

Signed Date

The ionising Radiation Regulations 2000 IR (ME)R require you to complete all the information
Incomplete / illegible forms will be returned

Bowel Preparation (to be completed by referrer)

There are no contraindication for this patient to be given bowl prep (if so, please state):

Billing

Self-funding	☐	Insured	☐
Medico-legal	☐	NHS	☐

Insurance company & price quoted

LMP (if required) Date

LMP to be ignored

Clinicians signature
Date

If outside date (10/ 28 day rule) please complete
I certify that there is no possibility I am pregnant

Signed Date

Radiographer Details

Dose

No. Exposures

Signature

Contrast Injection (complete if required)

Glaucoma	Y/N	Myeloma	Y/N
Renal failure	Y/N	Diabetic	Y/N

Creatinine: GFR: