CHESHIRE MEDICAL IMAGING

REFERRAL REQUEST FORM

		Surname:		Unit No:	
Site:		Forename:		NHS No:	
		Address:		DOB:	
				Gender:	
				Tel No:	
Patient Category:		Post Code:			

Phone/ Bleep:		Ward/ Dept:		Consultant/ GP:	
Examination Request:		Clinical Indications/Relevant Imaging:			
GMC/HPCP:					
GP Address:		Requested By:		Date:	
		Priority:			

Pregnancy Status Check (12-55)	Potential Hazard: Clinical Details
Are you or might you be pregnant? YES / NO / DON'T KNOW Only to be completed where relevant: Date last period started? * Within 10 days * With 28 Days LMP .... Comments .... Patient Sign: .... Date:	

Duty Holders	RIS Alert?:	Previous Imaging:
Operator:	RIS Number:	
Patient Identification:	Date Received:	Dose:
Pregnancy Status:	Height:	Screening Time:
Authorised By:	Weight:	WHO Check:
Practitioner:	Room:	
Comments:		