**Radiology Request Form – CT**



Clinical Imaging Facility,

Ground Floor ILS 2, Swansea University

Singleton Park, Swansea, SA2 8PP

Tel: 01792 606420

Email: CIFGroup@swansea.ac.uk

**All referrals must come from a registered medical professional. We cannot accept self-referrals.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Patient Surname:** |  | **Male**  |  | **Female** |  |
| **First name:** |  |
| **Date of Birth:** |  | **Funding:**  |
| **Address:** |  | **Self Funding** |  |
| **Postcode:** |  | **Private/Other**  |  |
| **Tel:** |  | **Patients Insurance Company & Address:** |  |
| **Email:** |  |
| **NHS No:** |  | **Preauthorisation No:**  |
| **Please note:** Uninsured patients and patients without pre-authorisation are required to pay on the day of their appointment. Insured patients are liable for any fees not covered by their insurer. Please therefore ensure that cover is in place prior to booking a scan appointment.  |

|  |  |
| --- | --- |
| **Referral Information** | **Clinical Indications (to be completed):** |
| **Examination Requested:** |  |  |
| **EGFR:** |  |
| **Date of blood test:** |  |

|  |
| --- |
| Any recent x-rays or scans. |

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| **Safety Questions** |
| Could the patient be pregnant? | Yes | No | LMP Date:  |
| Is the patient breastfeeding? | Yes | No | Is the patient taking Metformin? | Yes | No |
| Is the patient diabetic? | Yes | No | Does the patient have any allergies? | Yes | No |

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| --- |
| **Referring Clinician’s details:** *IR(ME)R 2000 regulations require this form to be signed by referring Clinician*.  |
| Consultant Name: |  | Address: |
| Signature: |  |
| Date: |  | Tel: |
| **Primary Contact****Number & Email** |  |  |
| **2nd Email OR Mobile number** |  |  |

**We are currently moving to an electronic system for the sending of images and scan reports. It is essential that a secure 2nd email OR mobile phone number is provided for this purpose. Please be aware that all sections MUST be completed. Incomplete referrals will not be accepted and will be returned for completion.**

**To be completed By CIF Operator/ Practitioner only**

|  |  |  |
| --- | --- | --- |
| Examination Authorised By:Operator / Practitioner | Date: |  |
| Operators Notes (including protocol used): |  |
| Patient ID check:  | Yes  | No | Checked By: |  |
| Dose: |  | Contrast Agent Administered: |  |
| Operator Signature: |  | Date: |  |
| Reporting Radiologist: |  |
| Signature: |  |

Form to be filed for records, do not destroy.