Request for X-ray

KINGSBRIDGE Private Hospital ★★★★★

Patient ref number

WLI number

Referrers are required to complete sections 1-4 accurately and legibly. Inadequately completed forms will not be accepted.

1. Patient Details

Title		Forename		Surname	
DOB		Gender	☐ Male ☐ Female		
Address				Postcode	
Tel (Home)		Tel (Mobile)			

Patient Identification - For Kingsbridge Private Hospital use only.

I have confirmed the above patient's name, address and DOB.			Signed
☐ Verified by patient	If another/status		Signed

2. Cautions (if none, tick here ☐)

Diabetes mellitus: must be completed if patient is required to fast prior to procedure OR requires iv/a contrast media. ☐ Yes ☐ No

If **yes,** controlled by ☐ Diet ☐ Insulin ☐ Glucophage/Metformin

☐ Other (please specify)

Other Cautions ☐ Blind ☐ Deaf ☐ Mobility ☐ Impaired Cognitive Functioning

☐ Other (please specify)

Infection risk to staff ☐ MRSA ☐ Category 3

☐ Other (please specify)

3. Clinical details/notes. Please include provisional diagnosis or indication and indicate results of previous tests/imaging if applicable.

☐ LMP/Pregnancy status

Please send completed form by post or email to:
Kingsbridge Private Hospital, MRI, CT and Outpatients Centre, 801 - 805 Lisburn Road, Belfast, BT9 7GX.
T: +44 (0) 28 9073 5272 | E: imaging@kingsbridgehealthcaregroup.com | kingsbridgeprivatehospital.com

XR

4. Examination/procedure request:

Referrer **(print name)**		Signature		Date	
Address				Postcode	
Tel (home)		Mobile			
Appointment date		Apointment Time			

For operator/practitioner use only

Examination/procedure authorised by | Date

(Subject to a decision to proceed following completion of pregnancy status section on reverse, if relevant.)

For operator/practitioner use only

Pregnancy Status

This section must be completed for a female aged 12 – 55 years for procedures in which the primary x-ray beam irradiates the area between the diaphragm and upper femora.

A **Ascertain from the patient if she:**

- ☐ Is definitely not pregnant (Complete B & D. Proceed with exposure)
- ☐ Is definitely pregnant (Complete B & C)
- ☐ Might be pregnant (Complete B & C)

B Date of the first day of last menstrual period (LMP)

C **Practitioner must review justification for the proposed exposure**

- ☐ Justified (Complete D and proceed with exposure)

Practitioner's signature

Out of hours: Discussed with:

Operator's initials | Date

- ☐ Not justified procced as follows:

D

Patient's signature

Operator's signature

Date

Pharmaceutical prescription and contrast administration

Name	Strength	Dose/QTY	Batch no. & exp. date	Drawn up by	Checked by
Prescriber's signature			**Administered by**		

Examination/procedure details

Date	Examination	kVp	mAs	DAP Screening	Screening time	No. of images	Operator

Scan reporting and dispatch

Assigned to (Radiologist)		☐ Report Sent	☐ Disc Sent	Date	
Address sent to				Postcode	

Notes

For Kingsbridge Private Hospital use only.

This patient is:

☐ Insured ☐ Self-funding ☐ WLI ☐ Employer ☐ Occ Health/Screen

Insured company/trust			
Policy Number		Authorisation Number	