Imaging Referral

Letter ☐ Text ☐

Appt:

Methley Park Hospital

Methley Lane
Methley
LEEDS LS26 9HG

Tel: 01977 664 209
Fax: 01977 664 232

Ward Room No: | IP ☐ OP ☐

SAP'd ☐ Booked ☐ Q ☐ CC ☐

Title: | Surname:

First Names:

Address:

M ☐ F ☐ Date of Birth:

SAP Number:

Examination Required:

Modality: **XR** ☐ **US** ☐ **CT** ☐ **MRI** ☐ **Nuc Med** ☐

Body Area:

Have you Paused & Checked: Correct Body Area & Correct Side ☐

Telephone Numbers:

Home:

Mobile:

Clinical Information:

LMP Date:

OR

Sign ……………………………………..Date……………………………………

To the best of my knowledge I am not pregnant

Latex Allergy? ☐ Yes ☐ No

Additional Information:

Address for report:

Specific Radiologist required:

Referring Clinician:

Signature:

Date: ……………………………………………………………………………

Is the request Justified?	Yes	☐	No	☐
Has recent Imaging History been establised?	Yes	☐	No	☐
Has the Benefit Vs Exposure Risk been explained?	Yes	☐	No	☐
Has the Patient given consent?	Yes	☐	No	☐

Bowel Preparation: Please sign to confirm that the referred patient is suitable for laxative bowel preparation.

Sign: ……………………………………………………………………………………

FOR HOSPITAL USE: PP'd: ☐ Scanned: ☐ Charged: ☐

Projections	Images/Exp's	kV	mAs	Dose	Radiographer	Date	
							Drug: Batch: Expiry:
							Drug: Batch: Expiry:
Bill As:							Drug: Batch: Expiry: