*Appointments typically within 1 week*

Spire
Fylde Coast Hospital

# Self pay and Insured
# CT scan request

St Walburgas Road
Blackpool
FY3 8BP

Tel: 01253 308084
Fax: 01253 395453

**Date and time of appointment:**

**Referring clinician**:
Name:
Follow up appt date:
Address for report:

Postcode:
Telephone:
Fax:

**Patient details**:
Hosp No:
Surname:
Forenames:
Address:

Postcode:
DOB: Sex: M ☐ F ☐
Tel home:
Tel work/mobile:

**Urgent** ☐ **Non urgent** ☐ **In patient** ☐ **Out patient** ☐

**Region to be examined:**

**Clinical details and results of previous investigations:**

**Provisional clinical diagnosis and question(s) you want the scan to answer:**

**Has the patient had a blood trest in the last 3 months? If so where?:**

**Signature of clinician:** **Print name:**
**Request date:**

**RADIOLOGIST USE**
**Protocol:**

**Contrast: Yes/No**
**Gastrografin prep/Water prep/None**

**Are you or might you be pregnant? Yes/No**

**Signed:** **Date:**

**Radiographers:** **Dose:** **Images:**
**Contrast:**

**Other medication:**
**Date:**