

Note: As a Referrer under the Ionising Radiation Medical Exposure Regulations 2000 (IRMER) YOU are responsible for providing sufficient information to allow for identification of the patient and justification of the examination. If you do not do this, the request form will be returned to you.

WEST DORSET GENERAL HOSPITALS – DIAGNOSTIC IMAGING REQUEST FORM	Surname Mr /Mrs / Miss		Date of Birth		Ward / Dept Code	Consultant Code	Extra Copy to	Grey box X-ray Dept Use only: X-ray No	
	First names				Bed <input type="checkbox"/> Stretcher <input type="checkbox"/> Chair <input type="checkbox"/> Oxygen required <input type="checkbox"/> Transport (Car <input type="checkbox"/> /Ambulance <input type="checkbox"/>)	Departmental ID procedure followed: Receptionists Signature: Operators Signature		Date of Examination	
	Address							Appt Time	
	Tel No:		G.P.		Hospital No		Occupation		Preparation Required
	Diabetic? Metformin?		Patient Barrier Nursed?		Any patient disabilities?		Previous Imaging?		This examination has been justified & authorised by: Name & Signature
	Yes / No Yes / No		Yes / No				Date:		
	Clinical History & indications for the examination – including allergies								<u>This MUST be completed for ALL female patients of reproductive age (menstruating).</u> <u>PREGNANCY STATUS</u> <u>Delete as applicable</u> PREGNANT NOT PREGNANT BREAST FEEDING First day of last period
	Clinical Question to be answered								
	Examination requested								
	Referrers Signature			Referrers Name (Please print clearly)			Bleep Number		Date (& Time, A&E only)

PLACE EXAMINATION LABELS IN THIS BOX

For Radiology Department Use Only

This MUST be completed for ALL female patients of reproductive age (menstruating).

I confirm that, to the best of my knowledge, I am not Pregnant.

Patients Signature

Dose () cGycm⁻²

Screening dose () dGycm⁻²

Screening Time () mins

Rm1/Dental/Mammo

Standard Exposure

Non Standard Exposure

KVp ()

mAs ()

Operators Comments (plus additional exposure details)

Optiray 350 300 240 please circle
Amount 100ml 75ml 50ml Other Volume:.....mls

Contraindications..... Signature.....

Operators Signature

Data entered on Flexirad