RADIOLOGY REQUEST FORM

SULIS HOSPITAL BATH

Sulis Hospital Bath
Foxcote Avenue
Peasedown St John
Bath BA2 8SQ

Radiology Appointment
Radiology Reception T: 01761 422250
Sulis E : radiology@sulishospital.com
NHS E : sulis.radiology@nhs.net

Date: .....
Time: .....

For billing purposes please tick correct box

NHS: ☐
Bill to patient: ☐
Bill to insurance/company: ☐
Bill to client account/consultant: ☐

Patient Name: .....
DOB: .....
Hospital Number X: .....
Address: .....

.....

.....

Daytime tel.no: .....
Mobile: .....

For females (12-55yrs):

LMP date:

Could you be pregnant: ☐ Y ☐ N

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

Referrer: .....
Address for results: .....

.....

.....

Tel: .....
Fax: .....
Date next appointment with Dr: .....

For all patients please also provide:

NHS patient no. :

For all insured patients please provide:

Insurer:

Membership no. :

Pre-authorisation no. :

Examination(s) Required:

Please include eGFR/Creatinine result for any CT requests.

For MRI patients:

Please notify department of any MRI contraindications prior to attending appt eg. history of intra-orbital foreign bodies, intracranial aneurysm clip, pacemaker, cochlear implants, prosthetic heart valve, pregnancy or any recent surgery.

Clinical Information: Examination cannot be performed without sufficient clinical information (Ionising Radiation Medical Exposure Regulations 2000):

Date: .....

Referrers e-signature : .....

Professional Registration number:

Justifies by: .....
Radiographer: .....
Date: .....
Rad dose:

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PROTOCOL / ADDITIONAL COMMENTS:

DRUGS/CONTRAST: