Diagnostic Imaging Request Form

Referring Hospital:

NHS Greater Glasgow and Clyde

* The Ionising Radiation (Medical Exposure) Regulations 2017 IR(ME)R require you to complete all this information accurately.

Information about departments in NHSGGC can be found at: **https://www.nhsggc.org.uk/about-us/professional-support-sites**
Select Diagnostic Services for Radiology Imaging or Nuclear Medicine as appropriate.

CHI: M☐ F☐
Surname: First Name(s):
Address:

Postcode: DoB:
Mobile: Phone: (**day and evening**):

Investigation(s) requested:

Pregnancy Rule

Observe: Ignore:

a. Is there any possibility that the patient could be pregnant – yes no
b. What was the date of the patients LMP:
c. Is the patient breastfeeding yes no

Patient Details	**Please complete for all outpatients**	Tracked patient?	**Transport**
Inpatient Outpatient	Is this a New Diagnosis?		Trolley: Chair:
Private patient Yes No	Is this a Planned Procedure?	YES	Oxygen: Drip:
Research study details:	Result required by MDT/Clinic on:	NO	Escort Required: Wheelchair used:
	Date:		

a.	Does the patient weigh over 18 stone (115kg)	yes	no	**AT RISK**
b.	Does the patient require oxygen litres	yes	no	Translator Y N Language BSL
c.	Does the patient suffer from incontinence	yes	no	MRSA: C Diff:
				Specify:

Clinical summary (to include indication and purpose of examination/intervention under IR(ME)R 2017):
What is the clinical question?

Please indicate any previous surgery or history of malignancy?
For malignancy please include site and stage of disease, biopsy/histology sites and results. FFor PET/CT include treatment dates and management plan if PET/CT is not available.

IV Contrast, CT, PET-CT, IVU/Intervention Patients

For contrast studies a recent eGFR is **mandatory.**
Also required for nuclear medicine GFR measurement
Current eGFR: Date of result:

OR ▸

This patient has no risk factors and can proceed to contrast medium without eGFR.
Initials:

Is your patient diabetic?	Yes	No	
If so, is this controlled by	Diet	tablet (metaformin)	Insulin
Has your patient had a contrast medium injection before?	Yes	No	
Does your patient have a known contrast medium allergy?	Yes	No	
Does your patient have severe or multiple allergies?	Yes	No	
Does your patient have asthma?	Yes	No	

MRI patients

Please indicate if patient has any of the following:

	Yes	No
A cardiac pacemaker?		
Surgery in the last 8 weeks?		
Aneurysm clipped/treated?		
Metal fragments in eyes?		
Previous cranial surgery?		
Any metal in the body?		
Claustrophobia?		

For interventions a coagulation screen is required in certain scenarios
For any interventions:
Is your patient on anticoagulants: Yes No Current INR/coagulation score:

Nuclear Medicine Patients

a. Is the patient on medication that may inhibit thyroid uptake e.g. thyroxin, amioderone
yes no

b. Does the patient have pulmonary hypertension
yes no Don't know

c. Does the patient suffer from a intrapulmonary or intracardiac shunt
yes no

Referrer's declaration: (NB: This form is a legal document under Ionising Radiation Medical Exposure Regulations 2017)

- **I certify that the correct patient details have been given**
- **I have taken into account the possibility of pregnancy**
- **I have given sufficient information for the request to be justified according to IR(ME)R 2017**
- **I know of no contraindication to performing the examination or intervention I have requested**

Referrer's signature:			Date:
Referrer Name:	Referrer Registration number GMC/NMC/HCPC:	Contact phone:	Contact email:
Consultant responsible:	Consultant's GMC number:	Phone if different:	Email if different: