NEW VICTORIA HOSPITAL

IMAGING DEPARTMENT REQUEST FORM

Telephone Enquiries: 020 8949 9030 Fax: 020 8949 9032 Email: imaging@newvictoria.co.uk

Referring Clinician: Address: Fax No. (for results): Tel No:	Surname: DoB: First Name: Address: Post Code: Tel No: Hospital No: Insurance Company: Policy No:

Clinical Information (IRMER requires a full history):

Patient Transport:

Inpatient ☐ Room No. .....

Walking ☐

Chair ☐

Bed ☐

Allergies ☐ .....

Asthmatic ☐

Diabetic ☐ Metformin Yes / No

Other ☐ .....

Examination(s) Required:

Signature: ..... Date: .....

I believe that I am not pregnant at the time of this examination.

LMP Date: .....

Signature: .....

Print Name: .....

For Imaging Department Use Only

Appointment Information

Date: .....

Time: .....

Contrast Information

Name: .....

Time: .....

Lot No.

Exp. Date: .....

Radiographer Justification

Initials: .....

Dose: .....

Date: .....