Imaging Department Request Form

Issue **January 2021** Review **January 2024**

184 Coombe Lane West, Kingston upon Thames, Surrey, KT2 7EG
Telephone Enquiries: **+44 (0) 20 8949 9030** Fax: **020 8949 9032** Email: **imaging@newvictoria.co.uk**

Referring Clinician: ______________________

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Address: ______________________

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Fax no. (for results): ______________________

Tel no.: ______________________

Surname: ______________________

First name: ______________________

Date of birth : ______________________

Address: ______________________

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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	☐	
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:
Print Name:

Contrast Information

Name
Time:
Lot No.:
Exp Date:

Radiographer Justification

Initials:
Dose:
Date: