Imaging Department Request Form

Issue March 2025 Review March 2028

NEW VICTORIA HOSPITAL

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

Referring Clinician: _____

_____

Address: _____

_____

_____

_____

_____

Fax no. (for results): _____

Tel no.: _____

Surname: _____

First name: _____

Date of birth : _____

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** ☐
- **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: