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| 1. **PATIENT DEMOGRAPHIC DETAILS**
 |
| NHS number : |  |
| First Name:  |  | Last name |  |
| Date of Birth (DD/MM/YY):  |  | Gender  | Male | Female |
| Address (1st Line):  |  |
| Town/City:  |  | Post Code |  |
| Contact Number\*:  |  | Other contact |  |
| Interpreter Required Yes/NO  | If yes – which language | Ethnic origin | Mobility (hoist required) |
| Impairments | Sight:  | Speech:  | Hearing:  |
| 1. **REFERRER- complete the following section**
 |
| Referrer Name |  | GMC number  |  |
| Referring Practice |  |
| Practice Address |  |
| Postcode |  | Telephone Number |  |
| Date of Referral |  | Referrer Signature\*\* |
| **2b. NOT REGISTERED – complete the following section if not registered** |
| nhs.net e-mail address: |  |
| Contact number |  |

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| 1. **EXAMINATION REQUESTED including body area to be imaged:**
 |
| Priority: Routine: [ ]  Urgent: [ ] Clinical Information/Concern: (as examination is protocol based, the quality of this information is important)Diabetic status:       Allergies:       |
| Question to be answered/Suggested Exam:  |
| 1. **CT CLINICAL CHECKLIST**
 |
| : **eGFR** – requests will be returned if this is not availablesee trust guidelines available on website | Result: | Date: |
| **LMP** | Date |  |
| For CT scans, patients must be within 10 days of the 1st day of their last period. Pregnancy test results will not be accepted. |

**\*Patients may receive text messages regarding the referral made from Guys & St Thomas’ Hopsital**

**\*\*An electronic signature will be accepted**

**Once Completed, all referrals must be sent via e-RS -** This service is cross mapped to Diagnostic Imaging, but all patients will be seen by the relevant Guys & ST Thomas’ Radiology Service.

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| **Specialty** | **Clinic type** | **Service name** |
| Diagnostic Imaging  | CT | Radiology |
| Diagnostic Imaging | MRI | Radiology |
| Diagnostic Imaging | Ultrasound | Radiology |
| Diagnostic Imaging | Fluoroscopy | Radiology |