Bath Imaging Partners LLP

RADIOLOGY REFERRAL FORM

Telephone 07855 617475 Fax 01225 825494 E-mail info@bathimaging.co.uk Website www.bathimaging.co.uk

Patient Details (affix label if available)	Referrer Details
RUH Number NHS Number Surname Forename Date of Birth Address Post Code Telephone Number GP Name/ Practice	Name Address for Report Post Code Telephone Number Date Referrers signature

Examination requested:	Known Allergies

Reasons for Referral /Clinical Details

After the referral form has been faxed [or E-mailed], the patient will be sent an appointment with all the necessary details about the scan. BIP appointments and appointment queries can also be made by phoning the relevant number below:

Ultrasound (01225) 825529 CT (01225) 825989 MRI (01225) 824072

Please allow time for the referral to be received and processed before phoning.

Examination Authorised By	Practitioner/Operator	Date
Practitioners Notes	Appointment details Booked Admission Y/N Date Time Transport Booked Y/N? Initials _____	Appt Letter Sent Date Appt Telephone Date
Patient ID Check	(Operator)	Date

Pregnancy Status (refer to department protocol and complete the following)

Patient Pregnant? Maybe/ Yes/ No LMP Date _____ Patient's Signature _____ Date _____

Examination justified by practitioner Yes/No Authoriser's Signature _____ Operator's initials_____

Breast Feeding ☐ Not Breast Feeding ☐ Checked by _____

Operator's Notes (including number of films for evaluation) ☐ Operator(s) undertaking exposure _____	Contrast Media / Drugs Administered

EXAMINATION PROCEDURE	Exam	Room	Kvp	mAs	Dose/Activity	Screening Time