|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 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 | |  | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| 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 available  see 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 |