DIAGNOSTIC & IMAGING CENTRE
KING EDWARD VII'S HOSPITAL

# Diagnostic Imaging Request Form

## The David Thompson Imaging Suite

Imaging Department, 50-54 Beaumont Street, London, W1G 6DW
Tel: 020 7467 4317 / 020 7467 4582 Fax: 020 7467 4395 Email: imagingsecretary@kingedwardvii.co.uk
If you require Breast Imaging please email breastimaging@kingedwardvii.co.uk or phone 020 7467 4584
Website: kingedwardvii.co.uk

Last amended: 13 September 2023

### Patient details

**Title***

**Surname***

**Forename***

How would you like to be referred to/ preferred name?

Hospital Number

**DOB (DD/MM/YY)***

Telephone

**Address*** *House number and Postcode sufficient*

Email Address

- Insured patients are asked to obtain pre-authorisation before their appointment
- Self-Pay patients are required to settle the account on the day and sign a consent form
- Please bring any previous imaging for comparison

### Is the patient pregnant or may be pregnant?

Yes ☐ No ☐ Date of LMP

### Safety checks for CT and MRI patients - does the patient have:

| | | | | |
|---|---|---|---|---|
| Cardiac pacemaker | Yes | ☐ | No | ☐ |
| Cranial aneurysm clips | Yes | ☐ | No | ☐ |
| Replacement heart valve, coils or stents | Yes | ☐ | No | ☐ |
| Claustrophobic | Yes | ☐ | No | ☐ |
| Cochlear implants | Yes | ☐ | No | ☐ |
| Diabetes with insulin pump or glucose reader (please remove) | Yes | ☐ | No | ☐ |
| Metal implants/prosthesis | Yes | ☐ | No | ☐ |
| Orbital/other metal fragments | Yes | ☐ | No | ☐ |
| History of renal impairment | Yes | ☐ | No | ☐ |
| Any contrast reactions | Yes | ☐ | No | ☐ |
| Any allergies | Yes | ☐ | No | ☐ |

### Does the patient require:

A Wheelchair Yes ☐ No ☐ A Hoist Yes ☐ No ☐

Hearing assistance Yes ☐ No ☐ Visual assistance Yes ☐ No ☐

### Where is the patient going next?

Clinic ☐ Home ☐

### Payment method

Inpatient ☐ Insurance ☐ Corporate Account ☐ Self-Pay ☐

Other

### Examination requested*

MRI 3T ☐ X-Ray ☐ CT ☐

Mammography ☐ Ultrasound ☐ Fluroscopy ☐

Cardiac Echo ☐ DEXA ☐

Exam area *Please specify*

### Clinical indications and clinical question*

### Preferred radiologist (optional)

### e_GFR

Date Value

### Referrer's details

**Full name***

**Telephone***

**Email***

**Address*** *House number and Postcode sufficient*

**Signature***

**Date***

Referrer's declaration

- The correct details have been provided
- I have discussed the examination, where appropriate and any intervention with the patient/guardian
- I have taken into account the possibility of pregnancy
- I have given sufficient clinical information for the request to be justified according according to IR (ME) R 2017
- I have completed all mandatory fields marked with an astrix (*), according to IR(ME)R 2017