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: 17 July 2025

Patient details

Title*

Surname*

Forename*

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

Hospital Number

DOB (DD/MM/YY)*

Telephone

Address* *Full Address required*

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