



**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 3203 Email: imagingsecretary@kingedwardvii.co.uk

If you require Breast Imaging please email breastimaging@kingedwardvii.co.uk or phone 020 7467 3204

Website: kingedwardvii.co.uk

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	☐	1.5T*	☐	Either	☐		
X-Ray	☐	CT	☐	Mammography	☐		
Ultrasound	☐	Fluroscopy	☐	Cardiac Echo	☐	DEXA	☐
Exam area	 Please specify						

*1.5T is only suitable for certain body parts. If the 1.5T is not suitable the 3T MRI will be used.

Clinical indications and clinical question*

Preferred radiologist

e_GFR

Date		Value	
------	----------------------	-------	----------------------

Referrer's details

Full name*	
Telephone*	
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 to IR (ME) R 2017
- I have completed all mandatory fields marked with an astrix (*), according to IR(ME)R 2017



**DIAGNOSTIC &
IMAGING CENTRE**
KING EDWARD VII'S HOSPITAL

Diagnostic Imaging Request Form

Imaging Department, 50-54 Beaumont Street, London, W1G 6DW

Tel: 020 7467 3203 Email: imagingsecretary@kingedwardvii.co.uk

If you require Breast Imaging please email breastimaging@kingedwardvii.co.uk or phone 020 7467 3204

Website: kingedwardvii.co.uk



1

Main Hospital

King Edward VII's Hospital, 5-10 Beaumont Street, London, W1G 6AA

2

King Edward VII's Hospital Medical Centre

(Outpatients, Imaging and Pharmacy)

54 Beaumont Street, London, W1G 6DW

3

Consultant Rooms and Extremity Scanner

King Edward VII's Hospital Emmanuel Kaye House,

37a Devonshire Street, London, W1G 6QA