Heart of England NHS
NHS Foundation Trust

Building healthier lives

Imaging Referral Form

Patient Details *Please write clearly and complete in BLACK ink*

PID …… NHS No ……

Surname …….. Address ……

Forename …… ……

DOB …….. Sex …… ……

Preferred Contact No …… Postcode ……..…….. Operator ID……

If Label used PRINT patient name in this box

Hospital ……..... Consultant ……

Ward / Dept …….. Speciality ……

Patient Category *please tick* NHS ☐ CATII ☐ Private ☐ Clinical Trial ☐

Mobility *please tick* Walk ☐ Chair ☐ Bed ☐ Mobile ☐ Escort ☐

Special Needs *please tick* Sight ☐ Hearing ☐ Interpreter ☐ Oxygen ☐ Barrier ☐

Procedure or Examination required

Clinical Information / Therapy

Clinical Questions & Relevant Information

Medical Status

Infection risk ……

Allergies ……..

Pregnancy

LMP …….

Breast Feeding

☐ Yes ☐ No

Exams requiring intravenous contrast

Renal Function

U&E Test Underway ☐

Creatinine Result

INR

Asthmatic

☐ Yes ☐ No

Diabetic

☐ Insulin ☐ Metformin

MRI please tick if the patient has the following

Pacemaker ☐ Aneurysm clips ☐

Metal foreign body ☐ Operation within 3/12 ☐

Referrer's Details (person completing the form)

Hospital Referrer

Referrer's name ……

Title ……..

Bleep / Mobile no. ……..

Signature ……

Date ……

GP or other non-Hospital referral

Referrer's name ……

Practice code/occupation ……

Practice Address ……..

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Failure to complete correctly will result in the form being returned

FOR CHEST X-RAYS – No appointment is required.

Please attend the Imaging Department on any weekday (exc. bank holidays) **between 9am - 4pm** at Birmingham Heartlands Hospital, Solihull Hospital or Good Hope Hospital (Treatment Centre - Area F).

Patients without an appointment will be dealt with on a first come first served basis and you may have to wait a short while.

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