

The Princess Grace Hospital

RADIOLOGY REQUEST FORM

42-52 NOTTINGHAM PLACE LONDON W1U 5NY
 X-RAY DIRECT TEL: 020 7908 2000
 MAIN DEPARTMENT FAX: 020 7908 2010
 C.T. APPOINTMENTS: 020 7908-2007
 MRI APPOINTMENTS: 020 7908-2011
 MAMMOGRAPHY/BREASTS ULTRASOUND: 020 7908-2003/4
 OSTEOPOROSIS APPOINTMENTS: 020 7908-2008

30 DEVONSHIRE STREET LONDON W1G 6PU
 X-RAY DIRECT TEL: 020 7908 3666
 X-RAY FAX: 020 7908 3665
 MRI APPOINTMENTS: 020 7908 3741
 MRI FAX: 020 7908 3739

Please tick as appropriate X-Ray US CT MRI

Please send all relevant imaging with patient

Patient Name: DoB:Hospital number: X Address: Daytime tel. no:Mobile No:	Radiology Appointment Date: Time:
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Referring Doctor: Address for Results: Tel: Fax: Next appointment with Dr:	CHECK LISTS: <u>For CT Scan, IVU & interventional procedures</u> Please indicate if the patient is Diabetic on Metformin? Y <input type="checkbox"/> N <input type="checkbox"/> Asthmatic/allergic to contrast? Y <input type="checkbox"/> N <input type="checkbox"/> Other allergies? Y <input type="checkbox"/> N <input type="checkbox"/> Taking Anticoagulants/antiplatelet drugs Y <input type="checkbox"/> N <input type="checkbox"/> e.g. warfarin, aspirin or Plavix (Clopidogrel) <i>If the answer is yes to any of these questions and you are unsure if this will affect the procedure, contact the X-Ray dept for guidance.</i> <u>For MRI patients:</u> Please note any MRI contraindications e.g.: history of intra-orbital foreign bodies, intra-cranial aneurysm clip, pacemaker, cochlear implants, prosthetic heart valve, pregnancy or any recent surgeries.
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Examinations(s) Required:	<u>For females (12-55yrs):</u> LMP date: Could you be pregnant? Y <input type="checkbox"/> N <input type="checkbox"/> Signed:Date:
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Clinical Information: <i>Examinations <u>cannot</u> be performed without sufficient clinical information (Ionising Radiation Medical Exposure Regulations 2000)</i>	Justified by: Radiographer: Date: Rad dose: Comments:
DOCTOR'S SIGNATURE: Date:	

TO BE COMPLETED BY RADIOLOGIST:

DRUGS	ROUTE	DOSE	SIGNATURE	DRUGS	ROUTE	DOSE	SIGNATURE
Buscopan 20mg/ml	IV / IM	20 mg		Lidocaine 1%		10 ml	
Maxalon Syrup 5 mg/5ml	ORAL	20 ml		Caverject 20 mcg	Intracav- ernosal	1 ml	
Glucagon 1 mg/m	IV / IM	1 mg		Contrast Media			
Gentamicin 80 mg/ml	IV / IM	120 mg					