Imaging Request Form

Please fax this form to: **020 3447 2898**

For appointments/enquiries, please call: **020 3447 2800**

INSTITUTE OF SPORT EXERCISE & HEALTH

170 Tottenham Court Road
London W1T 7HA

PLEASE SEND ALL RELEVANT IMAGING WITH THE PATIENT

Patient Name: .....

DoB: ...../...../..... Hospital No: **X**.....

Address: .....

.....

Daytime Tel: ..... Mobile: .....

Email: .....

(Females 12-55yrs): *LMP date:* .....

Could you be pregnant? ***Y / N***

Signed by patient: .....

Examination required:

Clinical indication:

Examinations cannot be performed without sufficient information in line with the Ionising Radiation (Medical Exposure) Regulations 2000

Referring Doctor: .....

Address for results: .....

.....

.....

Tel: ..... Fax: .....

Signed by referrer: .....

Date: .....

MRI: Does the patient have any of the following contraindications? (please tick)

	YES	NO
• History of intra-orbital fb	☐	☐
• Intracranial clips	☐	☐
• Pacemaker	☐	☐
• Cochlear implants	☐	☐
• Prosthetic heart valve	☐	☐
• Pregnancy	☐	☐
• Recent Surgery	☐	☐

Justified by: .....

Radiographer: .....

Date: .....

Rad dose: .....

Drugs/Contrast: .....

Additional comments: .....

.....

.....

Checklist for other procedures:

Patient information:	YES	NO
• Diabetic on Metformin	☐	☐
• Asthmatic or allergic to contrast	☐	☐
• Other allergies	☐	☐
• Any kidney problems	☐	☐
• Taking anticoagulants/antiplatelet drugs e.g. Warfarin, Aspirin or Plavix (Clopidogrel)	☐	☐

• EGFR result: ..... Date: .....

If the answer is yes to any of these questions and you are unsure if this will affect the procedure, please contact the Imaging Department for guidance.