***Inadequately completed forms will be returned***

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| **Patient Details** | **Pregnancy Status** *(Females 12-55yrs)* |
| **Full Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **DOB: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_ PCN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Male** **Female  Daytime Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Patient Category :** Public  Private Medico Legal  **Insurer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | *Certain radiology examinations in pregnancy can put the unborn infant at risk. Radiographic imaging of areas between diaphragm & knees should only be done between days 1 and 10 of cycle.*  **Pregnant** Yes  No **LMP** *:\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_*  Prior Hysterectomy Post-Menopausal  Waiver of LMP No Yes  if yes, explain\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***  ***If waiver LMP, you are taking responsibility for pregnancy status of patient.*** |
| **IV Contrast Examinations** | **Cautions** |
| Allergies: No  Yes specify……………………………  Creatinine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  eGFR : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date taken \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Renal Disease No  Yes  Diabetes No  Yes  Breastfeeding : No  Yes | **Mobility** Walking Wheelchair Trolley  **Infection risk N**  **Y**  **Other( specify**) e.g***.*** *blind, deaf, impaired cognitive function \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| **Referral Information** | |
| **Type of Exam: X-ray  CT  Ultrasound  Fluoroscopy Radioisotopes**  **Area(s) to be imaged**: ………………………………………………………………………..  **Reason for referral *( including clinical examination, duration of symptoms & differential diagnosis)***  ***………………………………………………………………………………………………………………………………………………***  ***………………………………………………………………………………………………………………………………………………***  ***………………………………………………………………………………………………………………………………………………***  ***………………………………………………………………………………………………………………………………………………***  ***………………………………………………………………………………………………………………………………………………*** | |
| **Referrer Details: GP Locum Trainee**(GP/NCHD**)  Consultant** | |
| Name(BLOCK)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  PLEASE  **STAMP**  Registration Number(MCRN) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ***PLEASE DISCUSS URGENT/COMPLEX CASES BEFORE submitting requests***  ***Your signature confirms you have read SUH referral guidelines ( available SUH website)***  **Doctor Signature: …………………………………………… Date: …………………** | |
| **Dept Use Only** | |
| **Exam Approved Yes \_\_\_ No \_\_\_\_ Needs More Info\_\_\_\_** Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **CT: IV Contrast Y □ N □ Oral Contrast Y □ N □ Other(s) Prep\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Vetting Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Timeslot Req:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |