***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:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |