

REFERRAL FOR DIAGNOSTIC IMAGING CENTRE

Surname		Male		Female	
Forename		Ward:			
Date of Birth	/ /	Walk		Trolley/Bed	
		Wheelchair		Portable	
MRN		Alert/Infection Risk:			
Primary Consultant		Allergies:			
Modality Requested (Please tick)					
Plain X-Ray		Mammography			
CT		DEXA			
Ultrasound		MRI			
Nuclear Medicine		PET/CT			
Interventional Radiology		Other			
Exam Required:					
Clinical Question to be Answered:					
Previous Investigations			Previous Operations		

Female Patients of Childbearing Age (12 – 55 years)					
First day of Last Menstrual Period (LMP):		/	/		
Pregnancy Declaration Form completed			Yes		No

Referring Clinician (please print)	
Medical Council Number	
Signature	
Date	