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| **RADIOLOGY REQUEST FORM**  **REFERRERS: PLEASE COMPLETE ALL BOXES BELOW & UPLOAD ONTO ERS**  **PLEASE DO NOT CHANGE ANY OF THE HEADINGS**  **RAPID DIAGNOSTIC SERVICE (RDS) PATHWAY** | | | **Enquiry Line: 01482 675140 / 624044** [**https://nww.ebs.ncrs.nhs.uk/**](https://nww.ebs.ncrs.nhs.uk/) | | |
| *Date Received:* | *Breach Date:* | | | *Appoint Date, Time Room & Site:* | |
| **Referring Practice:** | **Patient NHS / Hospital Number:** | | |
| **Patient Surname:** | **First Name:** | | | **D.O.B:** | |
| **Patient Address:** | | | | | |
| **Preferred Contact Number (patient):** | | | **Second Contact Number:** | | |
| **Does the patient have a personal history of cancer? Yes** **No** **Details:**  **Has the patient ever smoked? Yes** **No** **Current smoker?** | | | | | |
| Current Clinical details: (please select)  1. New unexplained & unintentional weight loss  2. New unexplained constitutional symptoms of four weeks or more (Loss of appetite, fatigue, nausea, bloating, malaise)  3a. New unexplained vague abdominal pain of four weeks or more  3b. Less than four weeks if very significant concern  4. New unexplained, unexpected or progressive pain (including bone pain) or four weeks or more  5. GP “gut feeling” of cancer diagnosis (reason to be clearly described at point of referral)  FIT test [<10 ] [10-150] [>150] [Not done] [Awaiting result] Delete as appropriate | | | | | |
| **Any addition clinical details:** | | | | | |
| **Any relevant issues we need to know: i.e. diabetic, mobility issues, transport issues, excessive BMI, communication barriers (i.e. sign language or interpreter services required?) Give details:** | | | | | |
| **Name of Referrer & Designation:** | | **Direct telephone number of referrer:** | | | **Practice B code***:* |
| *Vetted Code:* | | *Priority* | | | *Initials* |