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| **PLAIN FILM IMAGING REQUEST FORM** | | | **Enquiry Line: 01482 622047 (Option 1) CHH** | | | |
| *Received date:* | | *Breach Date:* | | | | *Appointment Date, Time, Room & Site:* |
| **Referring Practice:** | | **Name of referrer**: | | | |
| PRACTICE (B) CODE: | | **Direct telephone number of person referring:** | | | |
| **Practice Tel No:** | | **Patient NHS/Hospital Number:** | | | | |
| **Patient Surname**: | | **First Name:** | | | **DOB:** | |
| **Preferred Contact Number (patient):** | | **Address:** | | | | |
| **Alternative Contact Number:** | | **Examination(s) Requested:** | | | | |
| **Clinical Question Posed: (please state the problem and the questions to be answered)** | | | | | | |
| **Any relevant issues we need to know: i.e. mobility issues, transport issues, excessive BMI, allergies, communication barriers (i.e. sign language or interpreter services required?) Please provide details:** | | | | | | |
| **For female patients aged 12-50 years, can the patient exclude possibility of pregnancy?** Yes  No  If no, please place cross in box to proceed with exam | | | | | | |
| **SITE PREFERENCE (please select):**  HRI  CHH  BRANSHOLME HEALTHCENTRE  ERCH SWINEMOOR LANE BEVERLEY  NO PREFERENCE | | | | | | |
| Vetted Code: | Priority: | | | Vetter initials: | | |

**REFERRERS: PLEASE COMPLETE ALL BOXES BELOW & UPLOAD ONTO ERS**

**PLEASE DO NOT CHANGE ANY OF THE HEADINGS**