|  |  |
| --- | --- |
| **RADIOLOGY REQUEST FORM****REFERRERS: PLEASE COMPLETE ALL BOXES BELOW & UPLOAD ONTO ERS** **PLEASE DO NOT CHANGE ANY OF THE HEADINGS****CHEST XRAY FORM** | **Enquiry Line: 622047 (Option 1) CHH** **hyp-tr.HEYRadiologyEnquiries@nhs.net** |
| *Date Received:* | *Breach Date:* | *Appoint Date, Time Room & Site:* |
| **Referring Practice (including B code):** | **Patient NHS / Hospital Number:** |
| **Patient Surname:** | **First Name:** | **D.O.B:** |
| **Patient Address:** |
| **Preferred Contact Number (patient):** | **Second Contact Number:** |
| **Examination: Chest X-ray**  |
| **ARE YOU REQUESTING A CHEST XRAY BECAUSE OF THE POSSIBILITY OF CANCER?** | **YES** [ ] **NO** [ ]  |
| **Please indicate below if the patient is walking in or requires an appointment**  |
| **Walking in** [ ]  | **Appointment required** [ ]  |
| **Clinical Question Posed: (please state the problem and the questions to be answered)** |
| **Any relevant issues we need to know about: i.e. mobility issues, transport issues, excessive BMI, allergies, communication barriers (i.e. Sign language or interpreter services required?) Please provide details:** |
| **Name of Referrer &** **Designation:** | **Direct telephone number of referrer:** | **Practice B code***:* |
| *Vetted Code:* | *Priority* | *Initials* |