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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**