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| **CT IMAGING REQUEST FORM**  | **Enquiry Line: 01482 622043 CHH**  |
| *Received date:*  | *Breach Date:* | *Appoint Date, Time, Room & Site:* |
| **Referring Practice:**PRACTICE (B) CODE: | **Name of referrer:** |
| **PRACTICE B CODE:** | **Direct contact 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 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** [ ]  |
| **If IV contrast is required does the patient:** |
| **Suffer from Diabetes?****Yes** [ ]  **No** [ ]  | **Have known kidney disease (including transplant)?** **Yes** [ ]  **No** [ ]  | **Take Metformin? Yes** [ ]  **No** [ ]  |
| **If the answer is yes to any of the above, please provide current creatinine level (within 6 months and after patient started metformin treatment:****Current Creatinine level:**   **Date of test:** / / |
| Vetted Code: | Priority: | Vetter initials: |

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

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