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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**