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| **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* | |