Radiology Request Form
Sloane Diagnostic Imaging

Please tick as appropriate:

XRay ☐ CT ☐ Ultrasound ☐ MRI ☐

Area to be examined ______________________

Patient Name: ______________________ Title: ______________________

Date of Birth: ______________________ Male ☐ Female ☐

Patient Address: ______________________

____

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______________________ Postcode: ______________________

Telephone Numbers

Home: ______________________ Work: ______________________

In-Patient: ☐ Ward: ______________________ Name of Hospital: ______________________

Hospital Number: ______________________ Tel. Number: ______________________

Who is responsible for the patient's account? Patient ☐ Other ☐ NHS ☐

For MRI Patients please note any contraindications e.g. intra-orbital foreign bodies, intra-cranial aneurysm clip, pacemaker, cochlear implants, prosthetic heart valve, pregnancy or any recent surgery: ______________________

Clinical Information: ______________________

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Examinations cannot be performed without sufficient clinical information (Ionising Radiation Medical Exposure Regulations 2000)

Referrer's Signature: ______________________ Date: ______________________

Name of Referring Clinican: ______________________ Tel. Number: ______________________

Address for Report: ______________________

______________________ Postcode: ______________________

Appointment details: ______________________

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Females 12-55 years LMP Date

Are you Pregnant? Yes ☐ No ☐

Billing Code: ______________________

Reporting Radiologist: ______________________

To be completed by the radiographer

Operator: ______________________

Dose: ______________________

Date of Scan: ______________________

Please send or fax this form to:

Sloane Diagnostic Imaging
The Sloane Hospital, 125 Albemarle Road, Beckenham, Kent BR3 5HS
Tel: 020 8464 8197 Fax: 020 8464 7258 Email: sloane@alliance.co.uk