Gloucestershire CCG - RADIOLOGY REQUEST FORM (Form effective from 1st April 2013) Direct Access: CT, MRI *& NOUS*

Please complete the relevant sections and send to: (please insert provider name and location)
Provider Name: Cobalt Health (Imaging Centre) *Provider Location:* Linton House, Cheltenham
Fax No: 01242 535 919

Examination requested - tick CT or MRI	*Ultrasound (Non Obstetric)* ☒ *N/A AT COBALT*	**CT** ☐	**MRI** ☐

Body Area – *Please circle*
→ CT: Head - Chest - Abdomen - Pelvis

→ MRI: Head/Brain *(incl. dizzy pathway)* - Chest - Abdomen - Pelvis - Lumbar*(linked to back pathway)*

NHS NUMBER		GENDER	MALE ☐	FEMALE ☐
SURNAME		FIRST NAME		
ADDRESS				
POSTCODE		DATE OF BIRTH		
PATIENT HOME TEL NO:		PATIENT MOBILE NO:		

Clinical findings, previous ops, questions to be answered:

Weight: (Kg)	Other considerations: (e.g. Language, Interpreter, Hearing)		
REFERRER'S NAME IN CAPITALS		Date of request	
SURGERY NAME AND ADDRESS		Practice Code	
		Referrers signature (Electronic signature acceptable)	
SURGERY PHONE		SURGERY FAX	
COPY RESULTS TO			

FOR MRI CONTRA-INDICATIONS: ***Signing form implies NONE of the below apply: -***
Cardiac pacemaker; metal in orbit; internal hearing device; intracranial vessel clip; valve replacement; metallic foreign body; claustrophobia

FOR CT & MRI: is there a possibility the patient may be pregnant?	YES ☐	NO ☐

FOR CT WITH IV CONTRAST :	Recent eGFR: YES ☐ NO ☐	Date of eGFR: Result:

Does the patient have any of the following? Please mark (circle or tick) where applicable.

a) Previous reaction to IV contrast	YES ☐	NO ☐
b) Allergies	YES ☐	NO ☐
c) Diabetic	YES ☐	NO ☐
If yes, is the patient taking Metformin?	YES ☐	NO ☐
d) Has the patient had any imaging in the last 2 years?	YES ☐	NO ☐
If yes, where did the imaging take place?		