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| ***Please complete the relevant sections and send to: (please insert provider name and location)****Provider Name: Cobalt Health (Imaging Centre) Provider Location:* Linton House, CheltenhamEmail: CAF.bookings@nhs.net |
| Examination requested - tick CT or MRI  | *Ultrasound (Non Obstetric)* [x]  *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 MRI LUMBAR SPINE: *Referral does not meet the clinical criteria for direct access MRI if any of the below applies*. *Signing form implies patient has NONE: -*****1) Chronic back pain (>6weeks) without potentially serious features; 2) Acute back pain (≤6 weeks) without potentially serious features; 3) Suspected osteoporotic collapse; 4) Suspected osteomyelitis; 5) Symptoms are suggestive of cauda equina syndrome** |
| **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. |
| 1. Previous reaction to IV contrast
 | YES [ ]  | NO [ ]  |
| 1. Allergies
 | YES [ ]  | NO [ ]  |
| 1. Diabetic
 | YES [ ]  | NO [ ]  |
|  If yes, is the patient taking Metformin? | YES [ ]  | NO [ ]  |
| 1. Has the patient had any imaging in the last 2 years?
 | YES [ ]  | NO [ ]  |
|  If yes, where did the imaging take place? |  |