London NHS Diagnostic Service

X-RAY REQUEST FORM

PLEASE NOTE - WE ARE UNABLE TO ACCEPT REFERRALS FOR PATIENTS UNDER 18 YEARS OF AGE

Patient ID

NHS Number _____

First Name _____

Surname _____

Address _____

_____

_____ **Post Code** _____

Date of Birth _____

Telephone *(Home)* _____

Telephone *(Work)* _____

Telephone *(Mobile)* _____

Email Address _____

Gender Male ☐ Female ☐

Referring Clinician

Name _____

GMC/HPC/NMC No. _____

Address _____

_____

_____ **Post Code** _____

Referring PCT Code _____

Referring Practice Code _____

Telephone No. *(For urgent clinical findings)* _____

Fax No. _____

NHS Mail *(nhs.net only)* _____

Physical/Communication difficulties *(Specify if any)* _____

_____

If interpreter required, language _____

Religion _____

Ethnicity _____

Eligible for NHS Funded Transport Yes ☐

Car Transport Required Yes ☐

Wheelchair User Yes ☐

The patient must be ambulant, or if a wheelchair user they must be able to transfer independently on to the scanner or examination couch.

Clinical Indication/Problem

Please provide as much relevant clinical information as possible to ensure the most appropiate investigation is performed in accordance with The Ionising Radiation (Medical Exposure) Regulations 2000 and the 2007 Royal College of Radiologists' Referral Guidelines.

If the clinical information you provide indicates that the X-Ray requested is inappropriate we will contact you to suggest alternative imaging techniques.

Allergies *(specify, if any)*:

Investigation(s) required

Tick all required; please circle to qualify which side where appropriate.

☐	ABDOMEN			
☐	ANKLE	Left	Right	Both
☐	CERVICAL SPINE			
☐	CHEST			
☐	CLAVICLE	Left	Right	Both
☐	ELBOW	Left	Right	Both
☐	FACIAL BONES			
☐	FEMUR	Left	Right	Both
☐	FOOT	Left	Right	Both
☐	FOREARM	Left	Right	Both
☐	HAND	Left	Right	Both
☐	HEEL	Left	Right	Both
☐	HIP	Left	Right	Both
☐	HUMERUS	Left	Right	Both
☐	KNEE	Left	Right	Both
☐	LUMBO-SACRAL SPINE			
☐	MANDIBLE			
☐	ORBITS	**Foreign body only**		
☐	PELVIS			
☐	SCAPHOID	Left	Right	Both
☐	SCAPULA	Left	Right	Both
☐	SHOULDER	Left	Right	Both
☐	SKELETAL SURVEY			
☐	THORACIC SPINE			
☐	TIBIA/FIBULA	Left	Right	Both
☐	WRIST	Left	Right	Both
☐	Other			

For X-Ray examinations of females of child-bearing capacity, is there any possibility of the patient being pregnant?

Yes ☐ No ☐ Date of last menstrual period _ _ /_ _ /_ _ _ _

Referrer's Signature ..... Date of request _ _ /_ _ /_ _ _ _

Please post, fax or email this form to the InHealth (London) Referral Centre:
Hafley Court, Buckley Road, Rochdale OL12 9DN
Tel: 0844 581 0301 Fax: 0844 581 0305 Email: london.prc@nhs.net

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