RADIOLOGY REQUEST

Mid Essex Hospital Services

NHS NO: HOSPITAL NO: M/F SURNAME : FORENAME: DOB: ADDRESS: POSTCODE: TELEPHONE NUMBER	CONSULTANT/GP GP CODE: PRACTICE ADDRESS:	**WARD** ☐ WALKING ☐ CHAIR ☐ TROLLEY ☐ BED ☐ MOBILE ☐ AMBULANCE ☐ NHS ☐ PP ☐ CAT II

CLINICAL DETAILS: (**Please write clearly Relevant history including previous Radiology Examinations**) To be completed by a clinical referrer only

PLEASE TICK: 1 ☐ PLAIN X-RAYS 2 ☐ ANTENATAL US 3 ☐ ULTRASOUND 4 ☐ CT OR MRI SCAN 5 ☐ NUCLEAR MEDICINE 6 ☐ OTHER	**EXAMINATION REQUESTED:** KNOWN ALLERGIES: / DISABILITIES : ☐ Hay fever ☐ Asthma ☐ Eczema	IS THE PATIENT DIABETIC? YES/NO
DATE	SIGNATURE: Print Name Clinical Role – GP / Nurse Practitioner / Other (Please indicate)	
NO PREGNANCY RISK. PATIENT SIGNATURE ……..	LMP DATE ……	

Clinical referrers:

Please email your referrals to **mie-tr.MEHTRadiology.nhs.net**
In order to comply with current radiation regulations, any referrals which are incomplete or have inadequate clinical details will be returned to the referrer.
Please ensure the referral has been signed or sent from the referring clinician's email.

The Radiology Appointments team will than contact the patient to arrange an appointment.
For any appointment queries, please contact Radiology Appointments Team on **01245 514301**.

For Trust use only PRACTITIONER SIGNATURE	For Trust use only OPERATORS SIGNATURE