Text

Description automatically generated   
18-22 Queen Anne Street, London W1G 8HU

**Imaging/Injection Request Form**  
Please email the completed form to:

US scans & Injection referrals to: [outpatient@hssh.health](mailto:outpatient@hssh.health)

Xray referrals to: imaging@hssh.health  
This form will be uploaded to the patient’s clinical records.

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient Information: | | | | | | | | | | | | | | | | | | | | | | | | | |
| Title: | | | Surname: | | | | | | Forename: | | | | | | | | Date of Birth: | | | | | | | | |
| Address : | | | | | | | | | | | | | | | | | Hospital No: | | | | | | | | |
|  | | | | | | | | | | | | | | | | | Postcode: | | | | | | | | |
| Tel: | | | | | Mob: | | | | | | | | Email: | | | | | | | | | | | | |
| Insurer: | | | | | Policy No: | | | | | | | | Pre-Auth. No: | | | | | | | | | | | | |
| Self-funding: | | | | | Male | | | | | | | | Female | | | | | | | | | | | | |
| Billing: (Please Tick) | | | | | HSSH ⃣ | | | | | | | | HSSH Lite ⃣ | | | | | | | OS ⃣ | | | | | |  |
| Appointment: | | | Preferred Date: | | | | Preferred Time: | | | | | | To be reported by (if known): | | | | | | | | | | | | |
| Examination Requested: (MRI/CT/X-Ray/US/US Guided injection) | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| Clinical Indication for examination: *Please summarise relevant history, clinical findings & test results. Indicate the question that the examination should answer.* *Examinations CANNOT be performed without sufficient relevant clinical information & a Doctor’s signature, in line with Ionising Radiation Medical Exposures Regulations 2017.* | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Does the patient have any of the following *(tick if relevant)* | | | | | | | | | | | | | | | | | | | | | | | | | |
| Age over 65 | | | | Severe claustrophobia | | | | | | | Heart Conditions | | | | | | Pregnancy | | | | | | | | |
| Important: If Contrast is required for the scan: | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is there a history of kidney disease/surgery?  Yes No | | | | | | | Is there a history of dialysis?  Yes No | | | | | | | | Is the patient aged 65yrs or over?  Yes No | | | | | | | | | | |
| MRI: Does the patient have any of the following contraindications? | | | | | | | | | | | Checklist for CT scan, MRI and Interventional Procedures: | | | | | | | | | | | | | | |
| History of intra-orbital fb | | | | | | | Yes No | | | | Diabetic on Metformin | | | | | | | | | | | Yes No | | | |
| Pacemaker | | | | | | | Yes No | | | | Asthmatic or allergic to contrast | | | | | | | | | | | Yes No | | | |
| Intracranial clips | | | | | | | Yes No | | | | Other allergies | | | | | | | | | | | Yes No | | | |
| Prosthetic heart valve | | | | | | | Yes No | | | | Any kidney problems/dialysis | | | | | | | | | | | Yes No | | | |
| Cochlear implants | | | | | | | Yes No | | | | Taking anticoagulants/antiplatelet drugs  e.g Warfarin, Aspirin or Plavix (Clopidogrel) | | | | | | | | | | | Yes No | | | |
| Pregnancy | | | | | | | Yes No | | | |
| Recent Surgery | | | | | | | Yes No | | | | Serum creatinine / Estimated GFR / | | | | | | | | | | | | | | |
| Referring Consultant/GP - PLEASE COMPLETE ALL THE CONTACT INFORMATION BELOW | | | | | | | | | | | | | | | | | | | | | | | | | |
| Referred by: | | | | | | | | | | | Signature: | | | | | | | | | | | | | | |
| Hospital/Clinic: | | | | | | | | | | | Tel No: | | | | | | | | | Date: | | | | | |  |
| Report Req. by: | | | | | Email Address: | | | | | | | | Fax No: | | | | | | | | | | | | |
|  | | Radiographer Checklist (please initial) | | | | | | | | | | | | | | | | | | | | | | | | |
|  | |
|  | | Correct Patient | | | | | Correct Site | | | |  | |  | | Correct Procedure | | | | |  |  |  | |  |  |  |
|  | |  |  | | | |  | |  | | | | | |  | | | | |  |  |  | |  |  |  |
|  | | Operator: |  | | | | Dose: | | Screening Time: | | | | | | Date: | | | | |  |  |  | |  |  |  |
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Guidance Notes for Referrers

In accordance with the Ionising Radiation (Medical Exposures) Regulation 2017, the Harley Street Specialist Hospital Imaging Department would like to make all Referrers aware of the following Guidelines:

Referrals:

* A request for a Radiological Examination will be regarded as a request from one Clinician or Health Professional to the Radiology Department for an opinion based upon a radiological examination to assist in the management of a clinical problem.
* Diagnostic Imaging or radiological procedures will only be performed upon a written request signed by a Registered Medical or Dental Practitioner or by an authorised Non- Medical Practitioner.
* Signed referrals (request form or letter) must precede or accompany the patient.
* Only patients 18 or above can be seen at HSSH.
* All requests must carry sufficient information to identify the patient. This normally consists of first name, middle name if any, and family name, date of birth and address.
* All requests must carry sufficient clinical information to enable the requested examination to be justified. Referral criteria are based on the Royal College of Radiologists’ Guidelines - “Making the best use of a Department of Clinical Radiology: Guidelines for Doctors”.
* All requests shall clearly state the examination requested.
* All requests must include contact details of the Referring Clinician including address and telephone number.

Females of Childbearing Age (12-55 years)

* All requests for X-ray examinations (between the diaphragm and the knees) for females of childbearing age (12-55 years) must state the date of the first day of the patient’s menstrual period.

Clinical Justification of Requests:

* All requests for imaging will be assessed prior to exposure by the appropriate Practitioner for the examination to ensure that they meet with The Royal College of Radiologists’ Guidelines and any local Guidelines and that, in their professional judgement, they are clinically justified (Royal College of Radiologists Publication: BCFR(00)5).