

Request for CT



KINGSBRIDGE

Private
Hospital
★★★★★

Patient ID number:

- Dental CT CT
- CALCIUM SCORE only CT CARDIAC ANGIOGRAM (native)
- FUNCTION ANALYSIS required CT CARDIAC ANGIOGRAM (grafts)

Referrers are required to complete sections 1-4 accurately and legibly. Inadequately completed forms will not be accepted.

1 - Patient details

Title:	<input type="text"/>	Forename:	<input type="text"/>	Surname:	<input type="text"/>
DOB:	<input type="text"/>	Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Address:	<input type="text"/>				
Postcode:	<input type="text"/>	Tel (Home):	<input type="text"/>	Mobile:	<input type="text"/>

Patient Identification

For Kingsbridge
Private Hospital use only.

I have confirmed the above patient's name, address and DOB. Signed:

Verified by patient: If another/status: Signed:

2 - Cautions (if none, tick here)

- Pregnancy:** Yes No Date of LMP:
- Infection Risk:** MRSA Category 3
- Other cautions:** Blind Diabetes Impaired cognitive function Asthma Deaf Mobility Bronchospasm
- Allergies (please specify):
- Other (please specify):

At risk of contrast induced nephropathy

Risk factors include renal impairment, diabetes, myeloma, diuretic administration and illness likely to contribute to hypovolaemia.

Yes No If **YES:** Creatinine level: $\mu\text{mol/l}$ Date of test:

NB If creatinine level > 150 $\mu\text{mol/l}$ contrast will not be administered without specific approval of referring medical practitioner.

Approved by:

3 - Clinical details/notes. Please include provisional diagnosis or indication and indicate results of previous tests/imaging if applicable.

CARDIAC CT ONLY

To optimise image quality, HR of 60bpm is desirable.

Resting HR: If > 60bpm please prescribe medication prior to scan.

Contraindication to β -Blocker

Current β -Blocker medication:

Dosage prescribed:

Stop medication after scan

Arrhythmias (specify):

Atrial Fibrillation (may be a contraindication)

Implants:

Stents (specify):

ICD

Pacemaker

Grafts:

LIMA

RIMA

SVG (specify number and vessel):

ALL PATIENTS

Clinical details:

You are legally obliged under IR(ME)R NI 2000 to supply sufficient medical data for justification purposes.

Please send completed form by post, fax or email to:

Kingsbridge Private Hospital, MRI, CT and Outpatients Centre, 801 - 805 Lisburn Road, Belfast, BT9 7GX.

T: +44 (0) 28 9073 5272 | F: +44 (0) 28 9024 9929 | E: imaging@3fivetwo.com

4 - Examination/procedure request:

Referrer (print name):	Signature:	Date:
Address:		Post Code:

For operator/practitioner use only

Examination/procedure authorised by: Date:

(Subject to a decision to proceed following completion of pregnancy status section on reverse, if relevant.)

For operator/practitioner use only

Pregnancy status

This section must be completed for a female aged 12 - 55 years for procedures in which the primary x-ray beam irradiates the area between the diaphragm and upper femora.

A Ascertain from the patient if she is:

- Definitely not pregnant (Complete B & D. Proceed with exposure)
- Definitely pregnant (Complete B & C)
- Might be pregnant

B Date of the first day of last menstrual period (LMP):

C Practitioner must review justification for the proposed exposure

- Justified (Complete D and proceed with exposure)

Practitioner's signature:

Out of hours: Discussed with:

Operator's initials: Date:

- Not justified proceed as follows:

D Patient's signature:

Operator's initials:

Date:

Pharmaceutical prescription and contrast administration

Name:	Strength:	Dose/QTY:	Batch # & Exp. date:	Drawn up by:	Checked by:
Prescriber's signature:			Administered by:		

Examination/procedure details

Date:	Examination:	SOP (©):	Protocol:	Radiologist(s):
				Operator(s):

Scan reporting and dispatch

Assigned to (Radiologist): <input type="text"/>	<input type="checkbox"/> Report sent <input type="checkbox"/> Disc sent	Date: <input type="text"/>
Address sent to: <input type="text"/>		Post Code: <input type="text"/>

Notes

For Kingsbridge Private Hospital admin use:

This patient is:

- Insured
- Self funding
- WLI
- Employer
- Occ Health/Screen

Insurance company/trust:

Policy Number: Authorisation number:

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