Imaging Request Form

Cleveland Clinic London

In order to comply with the Ionising Radiation (Medical Exposure) Regulations (IRMER), please complete the information on this form and email to CCLREFERRALS@ccf.org or fax to 0207 890 4466

Patient Details	Referrer Details
Title:	Full name:
Surname:	GMC No.:
First name:	Practice Name:
Sex:	Street address:
Date of birth (DD/MM/YYYY):	Postcode:
NHS No. (if known):	Telephone No.:
Street address:	Email:
Postcode:	**Payment Details**
Telephone/ Mobile:	☐ Private Health Insurance ☐ Embassy Patient
Email:	☐ Self-Pay ☐ Sponsored

Clinical Information

Imaging modality: ☐ MRI ☐ CT ☐ Xray ☐ Ultrasound

Body part:	**Contrast:** ☐ With Contrast ☐ Without Contrast	**Priority:** ☐ Routine ☐ Urgent

Full clinical history and reason for exam/diagnosis:

Further comments (medications, allergies):

Is the patient over 260lbs / 120kg / 19 stone? ☐ Yes ☐ No

What is the patients mobility status?

CT Safety Questionnaire

Does the patient have any allergies or a history of adverse reaction to contrast?

☐ No ☐ Previous adverse reaction to contrast ☐ Allergies

Does the patient have asthma or a history of asthma?

☐ Yes ☐ No

Does the patient currently take Beta Blockers or Interleukin-2?

☐ No ☐ Beta Blockers ☐ Interleukin-2

Does the patient have any of the following medical risk factors?

☐ Yes ☐ Thyroid disease ☐ Myasthenia gravis
☐ Phaeochromocytoma ☐ Sickle cell disease

Does the patient have any of the following medical risk factors?

☐ Yes ☐ Known kidney disease (including kidney transplant) ☐ Currently on dialysis ☐ Hypertension ☐ Diabetes

MRI Safety Questionnaire

Does the patient have any cautions or contraindications for MRI?

- ☐ None
- ☐ Cardiac pacemaker
- ☐ Cardiac defibrillator
- ☐ Stimulators (brain, nerve, bladder)
- ☐ Intracranial aneurysm clips
- ☐ Cochlear implants
- ☐ Implanted drug pumps
- ☐ Endoscopic clip/stent

Has the patient had of the following surgeries?

- ☐ None
- ☐ Brain
- ☐ Heart
- ☐ Spinal
- ☐ Other (Please comment above)

Signature: _____ Date: _____