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| **GP Radiology Request** | | | | | | C:\Users\taylorde\Pictures\BHRUT Logo.jpg | | | | | |
| **INCOMPLETE / ILLEGIBLE FORMS WILL BE RETURNED in line with IR(ME)R 2017 regulations** | | | | | | | | | | | |
| **Please answer the following for *ALL* requests:-**  Version: 06-09-2021 | | | | | | | | | | | |
| **Lead GP/GP Name** | | | | **Hospital No** | | | | | **NHS No** | | |
| **Practice Name** | | | | **Surname** | | | | | | **Date of Birth** | |
| **Practice Code** | | | | **Forenames** | | | | | | | □ **Male** □ **Female** |
| **Practice Address**  (**All Fields are Mandatory**) |  | | | **Address:** | | | | | | | |
| **Clinical details/Relevant history**  (Include reason for urgency if applicable) | | | | **Postcode** | | | | | | | □ **NHS** □ **PP** |
| **Telephone** | | | | **Email** | | | |
| **Clinical question:** | | | | | | | |
| **Examination Requested:** | | | | | | | |
| With **IV Contrast** □ YES □ NO, if yes please answer section below | | | | | | | |
| Is this a **TRAUMA** request □ YES □ NO | | | | If Yes has Risk/Benefit been discussed with Patient □ YES □ NO | | | | | | | |
| **GMC Code** | | | | | | | | | | | |
| **Signature**  **Date** | | | **Referrer** (Print name) | | | | **Contact number (Please circle BLEEP/DECT/EXT)**: | | | | |
| **Patient Transport**: □ Walking □Chair □ Trolley □ Bed □ Portable □ Oxygen | | | | | | | **Ambulance required?** □ Yes □ No | | | | |
| **Pregnancy status** if applicable □ Not Pregnant □ Pregnant, if so Gestation weeks: | | | | | | | **LMP**: | | | | |
| **Patient alerts**: MRSA, Blind, Deaf, Translator required (Please specify language): | | | | | | | | | | | |
| **Diabetic Status** *(please tick)*  □ Not diabetic □ Diet controlled □ Oral hypoglycaemic □ Insulin dependent | | | | | | | | | | | |
| State any known **allergies**, especially to Radiographic contrast media (including the type of reaction if known) | | | | | | | | | | | |
| ***COMPLETE THIS SECTION ONLY IF EXAMINATION REQUIRES IV CONTRAST***  **If Contrast is requested and this section is not FULLY completed this form will be returned.** | | | | | | | | | | | |
| For Outpatient specify theeGFR = For Inpatient specify Serum Creatinine = Latest Blood Test Date: | | | | | | | | | | | |
| ***Between 9am – 5pm* for All patient’s with eGFR < 30 or Serum Creatinine >150 and known risk factors, Scan Must be discussed with Renal team OR On Call Medical team before discussion with Radiologist.**  ***Out of hours* for all patient’s with eGFR < 30 or Serum Creatinine >150 and known risk factors, Scans for life or limb threatening conditions discussion is required with On Call Radiologist, unless there are agreements in place for specific conditions.**  **If examinations are not discussed as above they will be done without contrast or will not be performed.** | | | | | | | | | | | |
| ***Please indicate known risk factors below*** | | | | | | | | | | | |
| On **Metformin** □ Yes □ No | | **Myasthenia gravis** □ Yes □ No | | | | **Hypercalcaemia** □ Yes □ No | | | | | |
| On **nephrotoxic drugs** □ Yes □ No | | **Hypertension** □ Yes □ No | | | | **Homocystinuria** □ Yes □ No | | | | | |
| **Hyperthyroidism** □ Yes □ No | | **Phaeochromocytoma** □ Yes □ No | | | | **Paraproteinemia/Myeloma** □ Yes □ No | | | | | |
| On **Interleukin – 2 Therapy**  □ Yes □ No | | **Asthmatic** □ Yes □ No | | | | **Homozygous Sickle cell** □ Yes □ No | | | | | |
| **Liver Impairment or peri-operative liver transplant period** □ Yes □ No | | | | | **Cardiac failure** □ Yes □ No Severity: | | | | | | |
| Please answer the following ***ONLY* for MRI examinations** | | | | | | | | | | | |
| **Cardiac pacemaker** □ Yes □ No | | | | | **Programmable hydrocephalus shunt**? □ Yes □ No | | | | | | |
| Any operations involving the use of **metal clips, pins, stent** or **implants**? □ Yes □ No  If known, **specify date** and **relevant details** including **type** of clip, implant etc. | | | | | | | | | | | |
| **COVID 19 STATUS** | | | | | | | | | | | |
| COVID Status □ Positive - Date of Swab □ Negative □ Suspected □ Not suspected | | | | | | | | | | | |
| **For Radiology Departmental Use Only** | | | | | | | | | | | |
| Justifier / authoriser  Signature    Date  Date last CT scan checked  □ tick | | **Authorising stamp/protocol here** | | | **Attach patient**  **attendance label**  **here** | | | | | | |
| I confirm that there is no possibility that I am pregnant. | | | | | Patient to sign: Date: | | | | | | |

**NOTES FOR PATIENTS REFERRED BY GPs**

**X-Rays Requests only**:

We now operate an appointment system, and all requests should be submitted through the designated mailbox below:

[bhrut.gpxrayrequests1@nhs.net](mailto:bhrut.gpxrayrequests1@nhs.net)

For CXR and suspected fractures, please hand the request form to the patient to attend in person to either King George Hospital or Queens Hospital and no appointment is required.

We aim to offer an appointment within 10 working days of receiving the request.

* Barking Community Hospital (Upney Lane) Monday – Sunday: 8.30am –7.30pm,

* Harold Wood Polyclinic (Gubbins Lane) Monday – Sunday: 8.30am –7.30pm,

* \***Queens Hospital (Rom Valley Way):** Monday – Sunday: 10.00am – 6.00pm
* **\*King George Hospital (Barley Lane)** Monday – Sunday: 10.00am – 6.00pm
* \*\*Fanshaw Diagnostic Centre (Dagenham) Monday – Friday: 08.30am - 4.30pm,

**St. George’s Hospital CDC (Suttons Lane, Hornchurch) will also be opening later in 2024**

**\*Please attend either Queens hospital or King George Hospital with suspected fractures relating to:**

1. Hip/Pelvis.
2. Skull.
3. Spines.

**\*\*Fanshawe Health Centre (Dagenham) only:** There is no x-ray service at the weekends & Bank Holidays

**All patients in need of transport are required to attend either King George or Queen’s Hospitals**

**Specialist Examinations** (Ultrasound, CT, MRI, Barium examinations, etc).

Requests for these procedures have to be checked by Radiology staff before an appointment can be made so that the

correct procedure is booked and any preparation can be arranged.

If your examination is for one of these, the requesting GP/Clinician should send the request via the designated email address.

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| **Modality** | **Sites** | **Call hours (Mon-Fri)** | **Contact number(s)** |
| **CT** | Queen’s & King George | 9:00am – 5:00pm | 0208 9708217 |
| **MRI** | Queen’s & King George | 9:00am – 5:00pm | 0208 9708217 |
| **Ultrasound** | Queen’s & King George | 9:00am – 5:00pm | 0208 9708217 |
| **Main Reception** | King George Hospital | 9:00am – 4:30pm | 0208 9708119 |
| **Main Reception (X-ray)** | Queen’s Hospital | 9:00am – 4:30pm | 0208 9708217 |
| **Barium Studies** | Queen’s Hospital | 8:45am – 5:00pm | 01708 435301 |
| **Interventional exams** | Queen’s Hospital | 9:00am – 5:00pm | 01708 503106 |
| **X-ray** | All sites | 9:00am – 5.00pm | 02089708217 |