Request for CT

Patient ID number:

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

KINGSBRIDGE Private Hospital ★★★★★

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

1 - Patient details

Title:		Forename:		Surname:	
DOB:		Gender: ☐ Male ☐ Female			
Address:					
Postcode:		Tel (Home):		Mobile:	

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

☐ Alergies (please specify):

☐ Other (please specify):

At risk of contrast induced nephropathy
Risk factors include renal impairement, diabetes, myeloma, diuretic administration and illlness likely to contribute to hypovolaemia.

☐ Yes ☐ No If **YES:** Creatinine level: µmol/l Date of test:

NB If creatinine level > 150 µmol/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 ß-Blocker

Current ß-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

CT

4 - Examination/procedure request:

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

For operator/practioner 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 signaure:			Administed by:		

Examination/procedure details

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

Scan reporting and dispatch

Assigned to (Radiologist):		☐ Report sent	☐ Disc sent	Date:	
Address sent to:				Post Code:	

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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