parkside hospital

CT REQUEST FORM

Parkside Hospital & Cancer Centre London	DEPARTMENT OF RADIOLOGY
53 Parkside Wimbledon London SW19 5NX Telephone: 020 8971 8000	Fax: 020 8947 1526 Email: radiology@parkside-hospital.co.uk

Referring Doctor	Patient Details
Doctor:	Surname:
Address:	First Names:
	D.O.B.:
	Clinic No:
	Address:
Tel No:	Tel No:

For female patients aged 12-55 years please enter date of L.M.P.

Is there any possibility you could be pregnant YES ☐ NO ☐

PLEASE TICK APPROPRIATE BOX:	I/P ROOM NO	O/P	WALK	CHAIR	STRETCHER	PORTABLE	THEATRE
	☐	☐	☐	☐	☐	☐	☐

CONTRAST STUDIES REQUIRE SERUM CREATININE / eGFR RESULT (TAKEN WITHIN LAST 3 MONTHS)

CREATININE LEVEL:	eGFR:

CLINICAL HISTORY (IRMER requires a full history):	EXAMINATION REQUESTED:

SPECIFIC QUESTION TO BE ANSWERED:

SIGN	DATE	Preferred Radiologist?

NOTE: INCOMPLETE REQUESTS WILL BE RETURNED, RESULTING IN DELAY OF BOOKING. Patients MUST bring outside Imaging for comparison

SAFETY CHECK

Does the patient have?	YES	NO
A History of Diabetes?	☐	☐
Any Allergies?	☐	☐
A History of Asthma?	☐	☐

For Radiographer use only

Comments:

Patient Dose:

IV Contrast Administered:

CT Colonography - Prescription

ITEM	Prescriber Signature & Date	Prescriber Name & Qualifications
☐ Gastrografin 100ml ☐ Bisacodyl 5mg Tablets		