BRADFORD HOSPITALS NHS TRUST
Diagnostic Imaging Department

Print all Sections Clearly

X-RAY REQUEST CARD

Appt.

All Sections in Part 1 must be completed or the examination may be delayed/cancelled (1R(ME) REG 2000)

Part 1

Surname: _____

Forename: _____ M/F: ____

DOB: ____/____/____ Hosp No: _____

Address: _____

_____

_____

Postcode: _____

Tel: _____

Ward: _____ OP: _____

Consultant (In full):

_____

Date: _____

Clinical History

Requirements:

Does this comply with the RCR Guidelines?

Differential Diagnosis

1. _____
2. _____
3. _____

Referring Clinician (please print)

Name: _____

Signature: _____

Designation: _____

Bleep No: _____

Contact No: _____

Previous Operations / Medical History

Details:

If a contrast injection is required this must be filled in.

Glaucoma	Y/N	Renal Failure	Y/N
Diabetic	Y/N	Myeloma	Y/N
Taking Metformin	Y/N	Previous Contrast Reaction	Y/N

High Dose Examinations should be performed within the 1st 10days of a Period

Females under 55yrs

1st day of LMP _____

Possibility of Pregnancy Y/N

Signature of Clinician to x-ray/scan if Pregnant

_____

TRANSPORT	INPATIENTS						OUTPATIENTS		
Booking No:	Chair	Drip	Trolley	Mobile	Theatre	O_2	Car 1	Car 2	Tail lift