

<b>CT Request</b> <b>Paul Strickland Scanner Centre</b> <b>Mount Vernon Hospital</b> <b>Northwood</b> <b>Middx HA6 2RN</b> Tel: 01923 886311 Fax: 01923 886313		Trial name/no. _____ Scan schedule day _____ Week _____ Date of Baseline _____ Standard of care <input type="checkbox"/> Commercial <input type="checkbox"/> Local <input type="checkbox"/> NCRN <input type="checkbox"/> RECIST Yes / No Other: _____		Appointment Date & Time:	
Surname:		Ref. type:	NHS	PP	Self-funding
First name:		NHS no:			
Address:		Hosp. no:			
ALL PATIENT DEMOGRAPHICS MUST BE COMPLETED		Ref. hosp. / GP surg.:			
OR THE REFERRAL MAY BE RETURNED		Pat. type:	Outpatient / IP Ward: _____		
Postcode:		Accessible information req'd?		Yes	No
Telephone no. 1:		Mobility:	Walking Wheelchair Trolley		
Telephone no. 2:		Hospital transport required?		Yes	No
		Interpreter required:		Specify Language	
DoB:	Male Female Not specified	For future scan in: (e.g. 3/12, 6/52)			
Examination required:					
Clinical details:					
Provisional diagnosis:					
Surgery performed (date & hospital):					
Previous RT/chemo (date):					
Reason for scan:					
Does the patient have the capacity to consent for the requested examination? YES/NO* (Delete as appropriate)					
<small>*If NO, please provide evidence of a best interests assessment in accordance with the requirements of the Mental Capacity Act (Consent Form 4)</small>					
Allergies		Previous imaging	Date	Place	
Pregnant	Yes No				
Asthma	Yes No	CT			
Infection control risk?	Yes No	MRI			
Mobility score? (E&NH)		PET/CT			
Renal Function:					
Please supply a serum creatinine result in line with the following guidelines:		Serum Creatinine: _____ Date: _____			
Stable patients – Creatinine ideally within 3 months of scan date		Estimated GFR: _____ Date: _____			
Higher risk patients e.g.: acute illness or renal disease – Creatinine ideally within 7 days		Blood Test Requested in line with guidelines stated above: <input type="checkbox"/>			
		Date blood test to be done: _____			
<b>Referrer's Declaration:</b> <ul style="list-style-type: none"> <li>The correct patient details are given</li> <li>I have taken into account the possibility of renal impairment (see above)</li> <li>I have discussed the examination with the patient/guardian.</li> <li>I have ensured that the patient is not pregnant.</li> <li>I have given sufficient clinical information for the request to be justified according to IR(ME)R 2017.</li> <li>I have considered the available guidelines (I-Refer and NICE Guidance) to ensure that this is the most appropriate imaging referral at the right time for the above-named patient.</li> </ul> I will ensure the examination results are placed in the patients notes		Referrer's name: _____ (print)			
		Grade/role: _____			
		GMC Number: _____			
		Referrer's signature: _____			
		Date of request: ____/____/____			
		Consultant: _____			
		Contact Tel: _____			
		<b>N.B. This form is a legal document</b>			

**For Staff Use Only:****Medication:**

Date	Drug	Dose	Route	Doctor's Signature	Batch No.	Expiry Date	Time given	radiog admin. Sig.	radiog checker sig.

**CVAD ACCESS**

Port used: Y / N

Port/Line observed for infection: Y / N

PICC Line used: Y/N

Dressing clean intact: Y / N / NA

Aseptic technique used: Y / N

Does port/line need review? Y / N

If yes, name of person informed:

	Batch Number	Expiry Date
Fiducial Markers		

**Clinical records**