CT Oral & Maxillofacial Request

Paul Strickland Scanner Centre
Mount Vernon Hospital
Northwood
Middx HA6 2RN
Tel: 01923 886311 Fax: 01923 886313

Trial name/no._____
Scan schedule day_____
Week____Date of Baseline_____
Standard of care ☐
Commercial ☐
Local ☐
NCRN ☐
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:

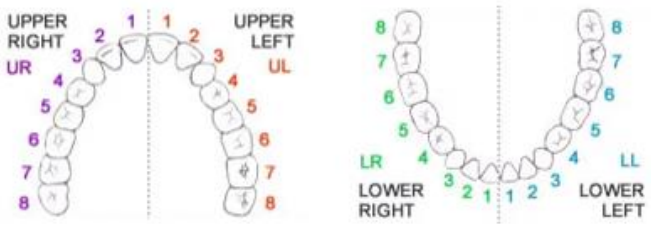
Clinical details:

Provisional diagnosis:

Surgery performed (date & hospital):

Previous RT/chemo (date):

Reason for scan:



Please circle or indicate the area of interest

Does the patient have the capacity to consent for the requested examination? YES/NO* (Delete as appropriate)
*If NO, please provide evidence of a best interests assessment in accordance with the requirements of the Mental Capacity Act (Consent Form 4)

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:
Stable patients – eGFR ideally within 3 months of scan date
Higher risk patients e.g.: acute illness or renal disease – eGFR ideally within 7 days

Estimated GFR : _____ **Date:**_____

Creatinine: _____ **Date:**_____

Blood Test Requested in line with guidelines stated above: ☐

Date blood test to be done:_____

Referrer's Declaration:

- The correct patient details are given
- I have taken into account the possibility of renal impairment (see above)
- I have discussed the examination with the patient/guardian.
- I have ensured that the patient is not pregnant.
- I have given sufficient clinical information for the request to be justified according to IR(ME)R 2017.
- 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.

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: _____

N.B. This form is a legal document

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