CT Request

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RESEARCH TRIALS

Trial name_____

RD number: RD20_____

Scan schedule day/week_____

Appointment Date & Time:

Surname:	**Ref. type:** ☐ NHS	☐ PP	☐ Self-funding
First name:	**NHS no:**		
Address: ALL PATIENT DEMOGRAPHICS MUST BE COMPLETED OR THE REFERRAL MAY BE RETURNED	**Hosp. no:**		
	Ref. hosp. / GP surg.:		
	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: **RECIST REQUIRED? (underline)** ☐ **NONE** ☐ **1.1** ☐ **iRECIST**

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)
*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