CT Request

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RESEARCH TRIALS

Trial name_____

RD number: RD20_____

Scan schedule day/week_____

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:	**Mobility:**	☐Walking ☐ Wheelchair ☐Trolley		
Email:	**Hospital transport required?**	☐Yes ☐No		
	Interpreter required: ☐Yes ☐ No	Specify Language		
DoB: ☐**Male** ☐**Female** ☐**Not specified**	**For future scan in:** (e.g. 3/12, 6/52)			

Examination required:

Clinical details:

RECIST REQUIRED? (tick box) ☐ **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 an eGFR 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 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 Name	Doctor's Signature	Batch No.	Expiry Date	Time given	radiog admin. Sig.	radiog checker sig.

CVAD ACCESS

Port used:☐Y☐N

Needle used:

PICC Line used:☐Y☐N

Port/Line observed for infection: ☐Y☐N

Aseptic technique used:☐Y☐N

Blood drawn back:☐Y☐N

Flushed well:☐Y☐N

Dressing clean intact:☐Y☐N☐NA

Signs of malposition:☐Y☐N☐NA

Signs of injection☐Y☐N If Y, please provide details:

Radiographer:

Clinical records