The Ionising Radiation (Medical Exposure) Regulations 2000 require you to complete this information accurately. Incomplete or illegible forms may be returned.

KENT AND SUSSEX RADIOLOGY GROUP

REFERRAL FORM

Telephone: 01892 633412 Fax: 01892 634468 E-mail: info@ksradiology.com Website: www.ksradiology.com

Contact: Private Secretary: 07986 540304

Patient Details (affix label if available)	Referrer Details
Hospital Number NHS Number Surname Forename Date of Birth Address: Post Code Telephone Number GP Name/ Practice	Name GMC or HPC No. Address for Report Post Code Telephone Number Referrers signature Date

Examination requested	Self-pay [ ] or Insured [ ]
Reasons for Referral /Clinical Details	Name of Insurance Company Policy Number Pre-authorization No.

For patients requiring i.v. contrast:		For MRI patients:		To be completed for female patients:
Is there a history of any of the following?		Does the patient have any of the following?		Could you be pregnant? Y [ ] N [ ]
Asthma	Y [ ] N [ ]	Cardiac pacemaker	Y [ ] N [ ]	Are you breast feeding? Y [ ] N [ ]
Diabetes	Y [ ] N [ ]	Heart valve replacements	Y [ ] N [ ]	1st Day of LMP (Date):
Metformin medication	Y [ ] N [ ]	Metal fragments in the eyes	Y [ ] N [ ]	Patient's signature:
Renal disease	Y [ ] N [ ]	Previous cranial surgery	Y [ ] N [ ]	
Contrast / Iodine allergy	Y [ ] N [ ]	Cochlear or metal implants	Y [ ] N [ ]	
Other Allergies	Y [ ] N [ ]	Any recent surgery	Y [ ] N [ ]	
If 'yes' what				

When the referral is received, the patient will be phoned to arrange a convenient appointment

For Completion by Imaging Department Staff	
Radiologist's protocol:	Appointment details: Initials _____ Hospital Date Time
Patient ID Check	(Operator) Date
Operator's Notes (including number of films for evaluation) ☐ Kvp: mAs: Dose(cGycm^2): Screening time: Operator(s) undertaking exposure:	Contrast Media / Drugs Administered