

\* The Ionising Radiation (Medical Exposure) Regulations 2017 IR(ME)R require you to complete all this information accurately.

Information about departments in NHSGGC can be found at: <https://www.nhsggc.org.uk/about-us/professional-support-sites>  
 Select Diagnostic Services for Radiology Imaging or Nuclear Medicine as appropriate.

CHI: <input type="checkbox"/> M <input type="checkbox"/> F Surname: _____ Address: _____  Postcode: _____ Mobile: _____	First Name(s): _____  DoB: _____ Phone: (day and evening): _____	<b>Investigation(s) requested:</b>  <b>Pregnancy Rule</b> <input type="checkbox"/> Observe <input type="checkbox"/> Ignore a. Is there any possibility that the patient could be pregnant – <input type="checkbox"/> yes <input type="checkbox"/> no b. What was the date of the patients LMP: c. Is the patient breastfeeding <input type="checkbox"/> yes <input type="checkbox"/> no
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<b>Patient Details</b> <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient Private patient <input type="checkbox"/> Yes <input type="checkbox"/> No Research study details: _____	<b>Please complete for all outpatients</b> <input type="checkbox"/> Is this a New Diagnosis? <input type="checkbox"/> Is this a Planned Procedure? Result required by MDT/Clinic on: Date: _____	Tracked patient? <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>Transport</b> <input type="checkbox"/> Trolley <input type="checkbox"/> Chair <input type="checkbox"/> Oxygen <input type="checkbox"/> Drip <input type="checkbox"/> Escort Required <input type="checkbox"/> Wheelchair used
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a. Does the patient weigh over 18 stone (115kg) <input type="checkbox"/> yes <input type="checkbox"/> no b. Does the patient require oxygen litres <input type="checkbox"/> yes <input type="checkbox"/> no c. Does the patient suffer from incontinence <input type="checkbox"/> yes <input type="checkbox"/> no	<b>AT RISK</b> Translator <input type="checkbox"/> Y <input type="checkbox"/> N Language <input type="checkbox"/> BSL <input type="checkbox"/> MRSA <input type="checkbox"/> C Diff Specify: _____
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**Clinical summary** (to include indication and purpose of examination/intervention under IR(ME)R 2017):  
 What is the clinical question?  
  
 \_\_\_\_\_  
  
 Please indicate any previous surgery or history of malignancy?  
 For malignancy please include site and stage of disease, biopsy/histology sites and results. FFor PET/CT include treatment dates and management plan if PET/CT is not available.

<b>IV Contrast, CT, PET-CT, IVU/Intervention Patients</b> For contrast studies a recent eGFR is <b>mandatory</b> . Also required for nuclear medicine GFR measurement Current eGFR: _____ Date of result: _____	OR ▶	This patient has no risk factors and can proceed to contrast medium without eGFR. Initials: _____																							
Is your patient diabetic? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, is this controlled by <input type="checkbox"/> Diet <input type="checkbox"/> tablet (metformin) <input type="checkbox"/> Insulin Has your patient had a contrast medium injection before? <input type="checkbox"/> Yes <input type="checkbox"/> No Does your patient have a known contrast medium allergy? <input type="checkbox"/> Yes <input type="checkbox"/> No Does your patient have severe or multiple allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No Does your patient have asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>MRI patients</b> Please indicate if patient has any of the following: <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td>A cardiac pacemaker?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Surgery in the last 8 weeks?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Aneurysm clipped/treated?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Metal fragments in eyes?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Previous cranial surgery?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Any metal in the body?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Claustrophobia?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>		Yes	No	A cardiac pacemaker?	<input type="checkbox"/>	<input type="checkbox"/>	Surgery in the last 8 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	Aneurysm clipped/treated?	<input type="checkbox"/>	<input type="checkbox"/>	Metal fragments in eyes?	<input type="checkbox"/>	<input type="checkbox"/>	Previous cranial surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Any metal in the body?	<input type="checkbox"/>	<input type="checkbox"/>	Claustrophobia?	<input type="checkbox"/>	<input type="checkbox"/>
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For interventions a coagulation screen is required in certain scenarios For any interventions: Is your patient on anticoagulants: <input type="checkbox"/> Yes <input type="checkbox"/> No Current INR/coagulation score: _____																									

<b>Nuclear Medicine Patients</b> a. Is the patient on medication that may inhibit thyroid uptake e.g. thyroxin, amioderone <input type="checkbox"/> yes <input type="checkbox"/> no	b. Does the patient have pulmonary hypertension <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> Don't know	c. Does the patient suffer from a intrapulmonary or intracardiac shunt <input type="checkbox"/> yes <input type="checkbox"/> no
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**Referrer's declaration: (NB: This form is a legal document under Ionising Radiation Medical Exposure Regulations 2017)**

- I certify that the correct patient details have been given
- I have taken into account the possibility of pregnancy and discussed the risk/benefit with the patient
- I have given sufficient information for the request to be justified according to IR(ME)R 2017
- I know of no contraindication to performing the examination or intervention I have requested

Referrer's signature: _____	Date: _____		
Referrer Name: _____	Referrer Registration number GMC/NMC/HCPC: _____	Contact phone: _____	Contact email: _____
Consultant responsible: _____	Consultant's GMC number: _____	Phone if different: _____	Email if different: _____