CT Patient Request Form

North West Cardiac Imaging Centre

Area to be examined: _____

Patient Name: _____ Title:

Date of Birth: _____ Male ☐ Female ☐

Patients Hospital Number: _____ NHS Number: _____

Patient Address: _____

_____

_____ Postcode: _____

Telephone Numbers Home: _____ Mobile: _____

In-Patient: ☐ Ward _____ Name of Hospital : _____

Hospital Tel. Number: _____

Who is responsible for the patients account? Patient ☐ Other ☐ NHS ☐

Clinical Information : _____

_____

_____

_____

_____

Examinations cannot be performed without sufficient clinical information (Ionising Radiation Medical Exposure Regulations 2000)

Referrer's Signature: _____ Date: _____

Name of Referring Clinician: _____ Tel. Number: _____

Address for Report: _____

_____ Postcode: _____

Appointment details: _____

Protocols required: _____

_____

Patient Information

Allergies: No ☐ Yes ☐ If yes, please give details _____

Diabetic: No ☐ Yes ☐ If yes, how is it controlled? _____

Has the patient any renal impairment? Yes ☐ No ☐

Recent eGFR _____ Date: _____

eGFR must be within the last 3 months. If not please arrange blood tests prior to scan appointment.

Females 12-55 years LMP date. Are you pregnant? Yes ☐ No ☐

Billing Code: _____ Operator: _____

Reporting Radiologist: _____ Dose: _____ Date: _____

Please send your referrals to:

North West Cardiac Imaging Centre, North West Heart Centre, Southmoor Road, Manchester M233 9LT
Tel : 0161 291 4560 E : admin.wyth@alliance.co.uk