Radiology request

Date
To
Request no.

Patient	Date of birth	MRN
Address		

Priority and cover

☐ Routine ☐ Urgent ☐ 2-week Cover

Examination

☐ Ultrasound ☐ X-ray ☐ CT ☐ MRI
☐ DEXA ☐ Mammography ☐ Fluoroscopy ☐ Other

Examination requested

Side / region

Contrast

Clinical question

Safety checks

☐ Pregnancy excluded or not applicable
☐ Possible pregnancy, LMP needed
☐ No renal impairment
☐ Pacemaker or metal implant (MRI)
☐ Contrast allergy
☐ Diabetic on metformin

Booking

Date

Signature

IMC no.