EQUEST SYSTEM DOWNTIME - SUHT RADIOLOGY REQUEST FORM

This form must only be used in the event of the eQuest system being unavailable. Please complete all the details on the form and deliver to Radiology. Failure to do so may mean that the examination cannot be performed.

Patient Details

Please complete all the following patient details or attach a sticky label.

Patient no: **NHS no:**

Patient name: **DOB:**

Address: **Sex:** *(please circle)* Male/Female

GP:

Phone No:

Request Details

Referral source: **Priority:** 2 wk cancer / Planned / Routine / Urgent

Requester: **Category:** *(please circle)* Cat 2 / NHS / Overseas / Private

Clinical lead:

Mobility: *(please circle)* Bed / Carried by adult / Chair / Hospital transport / Portable / Trolley / Walking

Request date: ……./……/…… **Pregnant:** Yes / No **LMP:** ……./……/……

Clinical Details

Radiology Clinical Details:

Requested Examination(s):

Research trial: Yes / No **Name:** **Escort required:** Yes / No

Hoist required: Yes / No **Additional needs:**

Infection risk: Yes / No **Diabetic:** Yes / No / Unknown

Other allergies / relevant medical conditions:

Signed:…….. **Bleep / Tel no:**…….

Contrast procedures only:

Last eGFR result:…….**ml/min** **Date:** ……./……/…… **Contrast / iodine allergy:** Yes / No / Unknown

Last Creatinine result:……**umol/l** **Date:** ……./……/……

MRI procedures only - Declaration

By submitting this form, I confirm that this patient satisfies all requirements specified within the referring doctor's declaration on safety and the MRI Patient Checklist

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RADIOLOGY USE ONLY

Appointment details: Date: ……../……./…….. Day: ……..Time: ……. Room:……..

Referral arrived on: ….. /……/…….at: ……..... Next clinic appointment on:……..

Identification check: by reception: NAME ☐ ADDRESS ☐ DOB ☐ checked by: ……..

Identification check: by operator: NAME ☐ ADDRESS ☐ DOB ☐ checked by: ……..

Information obtained from: Patient ☐ Relative ☐ Staff ☐

Operator details: Operator signature …….. Radiographer ☐ Assistant ☐ Other ☐……..

2nd operator signature …….. Radiographer ☐ Assistant ☐ Other ☐……..

Please attach EPISODE LABELS and record PRACTITIONER'S INSTRUCTIONS overleaf