**ALL DETAILS MUST BE COMPLETED IN FULL, INCOMPLETE REFERRAL FORMS WILL BE RETURNED IN LINE WITH IRMER 2017 REGULATIONS.**

GP radiology referrals for Planar X-rays and Ultrasound Imaging to University Hospital Southampton NHS Foundation Trust (Southampton General Hospital, Royal South Hants Hospital and Princess Anne Hospital should be made via **ICE** pathology requesting system. Internal referrals should be submitted via **EQuest**.

**Please only refer patients to UHS where their local centre is unable to provide the imaging**.

**Non-Medical referrers can only refer patients for imaging within their scope of practice**.

***This adult (age 16 and over) service referral form is for external providers only.***

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| --- | --- | --- | --- | --- | --- |
| **Patient Details** | | | | | |
| Patient Name | | | | | |
| Patient’s Address | | UHS Hospital Number (if known) | |  | |
| Date of birth | |  | |
| NHS number | |  | |
| Landline Number | |  | |
| Mobile phone number | |  | |
| Email address | |  | |
| Weight | |  | |
| Height | |  | |
| Mobility: | | Transport required: Yes/No | |
| **Requester Details** | | | | | |
| Referrer Name |  | | GMC / DMC Number | |  |
| Referrer Telephone number |  | | Referrer speciality | |  |
| Referrer contact details- email address, practice address/hospital address |  | | | | |
| **Request Details** | | | | | |
| Date of referral |  | | Priority (please indicate) | | 2WW/Urgent/Routine |
| Interpreter required? (Please specify native language) | Yes No  Comments: | | Additional needs- requirements e.g., hoist, learning difficulties etc. | | Yes No  Comments: |
| **Please state why this scan needs to be performed at UHS?** |  | | | | |

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| **Service Specific Referral Information** | | | | |
| **Radiological Imaging Examination Requested (Please indicate modality and body part)** | | X-ray Ultrasound  CT MRI (see safety questionnaire)  Body part: ………………………………………………… | | |
| **Clinical question to be answered?** | |  | | |
| **Relevant clinical history**  Please also note any recent imaging carried out | |  | | |
| eGFR for CT/MRI including date  (Within last 3 months) |  | | Is the patient pregnant? (If yes, please state number of week) | Yes No  ……Weeks | |
| Is the patient diabetic? | Yes No | | Is the patient breastfeeding? | Yes No | |
| List any known allergies  (if contrast media please give details) |  | | | | |

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| **MRI Safety Questions for MR referrals** | | |
| Any operations or procedures in the last 6 weeks? | Yes/No | If yes please specify   * What? * When? Date of procedure * Where? (Hospital site) |
| Any accidents in lifetime with metallic fragments entering the eyes? | Yes/No | If yes please specify   * What? * When? * Did you attend hospital to have removed?   If no, an IOFB x-ray may be required. Review of previous imaging on receipt of this form by UHS will be performed. |
| Does the patient have a cochlear implant? | Yes/No | If yes, please provide details via email to [implants.MRIsafety@uhs.nhs.uk](mailto:implants.MRIsafety@uhs.nhs.uk).   * The implant (make/model), * implantation date * centre of implantation |
| Does the patient have an active cardiac device (PPM/CRT/REVEAL/ DEFIB) | Yes/No | If yes, please provide the following details via email to [implants.MRIsafety@uhs.nhs.uk](mailto:implants.MRIsafety@uhs.nhs.uk).   * Make/model/serial number/implantation date of the generator and all leads * Which hospital implanted the device? |
| Does the patient have a stimulator? (Spinal cord/ deep brain/ vagal nerve) | Yes/No | If yes, please provide the following details via email to [implants.MRIsafety@uhs.nhs.uk](mailto:implants.MRIsafety@uhs.nhs.uk).   * Make/Model of IPG and all leads (serial numbers and lead numbers) * Detail of implantation date and hospital site of implantation |
| Does the patient have any other metallic implant in their body? | Yes/No | If yes, please provide details via email to [implants.MRIsafety@uhs.nhs.uk](mailto:implants.MRIsafety@uhs.nhs.uk).   * Implant type * When it was implanted   Which hospital it was implanted in? |
| Has the patient ever swallowed a Pillcam? | Yes/No | If yes, please provide details   * When?   Has it passed through and exited the body? Yes/No. If no, the patient may require an abdominal X-ray. |

**REFERRER’S DECLARATION (please note this is a legal document). If this is incomplete the referral will be returned to the referrer. This referral MUST have written signature.**

As a referrer under the Ionising Radiation (Medical Exposure) Regulations 2017, I have provided sufficient information to allow for identification of the patient and justification of the examination. I understand that if I do not provide sufficient information, this request will be rejected, and this may delay my patients care.

**Name:**

**Signature**:

 Email completed forms to:

* For Planar X-ray and Ultrasound - [**uhs.mainradiologybooking@nhs.net**](mailto:uhs.mainradiologybooking@nhs.net)
* For Cardiac CT and MRI - [**uhs.cardiothoracicradiology@nhs.net**](mailto:uhs.cardiothoracicradiology@nhs.net)
* For General MRI - [**uhs.**](mailto:uhs.)**mribookings@nhs.net**
* For General CT- [**uhs.ctbookingteam@nhs.net**](mailto:uhs.ctbookingteam@nhs.net)

**Email Safety/Implant details for MRI to** [**implants.MRIsafety@uhs.nhs.uk**](mailto:implants.MRIsafety@uhs.nhs.uk)**.**

For advice and guidance contact radiology via the eRs advice and guidance pathway:

**Radiology- (advice and guidance)-Southampton-UHSFT-RHM.**

Radiology department at Southampton general hospital- 023 8120 4015