**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 NoComments:  | 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.* 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.* 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.* Make/Model of IPG and all leads (serial numbers and lead numbers)
* Detail of implantation date and hospital site of implantation
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| 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.* 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**
* For Cardiac CT and MRI - **uhs.cardiothoracicradiology@nhs.net**
* For General MRI - **uhs.****mribookings@nhs.net**
* For General CT- **uhs.ctbookingteam@nhs.net**

**Email Safety/Implant details for MRI to** **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