GP Imaging Referral

The Royal Orthopaedic Hospital NHS Trust

PLEASE COMPLETE A SEPARATE REFERRAL FOR EACH IMAGING MODALITY REQUIRED

PLEASE ENSURE THIS REFERRAL IS COMPLETED FULLY, FAILURE TO DO SO MAY RESULT IN A DELAY

PATIENT DETAILS

Name:

Address:

Post code

Date of birth:

Telephone: ______________________(home)______________________ (mobile)

Gender: Male ☐ Female ☐

Eligible for transport: Yes ☐ No ☐

Transport required: Yes ☐ No ☐

If Interpreter required, language? ______________________

REFERRING CLINICIAN (Doctor only)

Name:

Address:

Post code:

Telephone:

Email:

INVESTIGATION REQUIRED

Knee ULTRASOUND ☐ XRAY ☐ MRI (COMPLETE SECTION BELOW) ☐

Hip ULTRASOUND ☐ XRAY ☐

ULTRASOUND ONLY

Elbow ☐ **Hand / Wrist** ☐ **Foot/ Ankle** ☐

Soft Tissue / Lump ☐ **Other (Please specify)** ☐ ______________________________

Shoulder - Please note: For Ultrasound requests of the shoulder please use the separate dedicated referral form.

CLINICAL INDICATIONS

(Referral should be made in line with The Royal College of Radiologists Imaging Referral Guidelines)

Is there any possibility of the patient being pregnant? Yes ☐ No ☐ Date of last menstrual period (dd/mm/yyyy): ____

Patient Allergies ____

Is the patient: Diabetic YES ☐ NO ☐ Patient on Warfarin YES ☐ NO ☐

MRI KNEE REFERRALS ONLY

R ☐ **L** ☐

Suspected Meniscal Tear ☐

Suspected Ligament Damage ☐

Locked Knee Pain ☐

Other reason (specify)

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____

Failure to fully answer the following primary MRI safety screening questions at the time of referral, may delay patient treatment. Does the patient have:

	YES		NO	
A Pacemaker	YES	☐	NO	☐
Aneurysm Clips or Coils	YES	☐	NO	☐
Programmable Hydrocephalus Shunt	YES	☐	NO	☐
Neuro Stimulator	YES	☐	NO	☐
Cochlear Implants	YES	☐	NO	☐
Proven Intra-orbital Metallic foreign Body	YES	☐	NO	☐
Cardiac Stent /any other Heart Surgery	YES	☐	NO	☐
Intrauterine Device	YES	☐	NO	☐
ANY other implant or device	YES	☐	NO	☐

Please state all implant/safety concerns below:

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IF IONISING RADIATION IS USED, I CONFIRM I HAVE EXPLAINED THE RISKS AND BENEFITS TO THE PATIENT *(IR(ME)R 2017)*

REFERRERS SIGNATURE: **PRINT NAME:**

DATE: **PROF REG** *(GMC)*:

MRI Department, Royal Orthopaedic Hospital, Bristol Road South, Northfield, Birmingham, B31 2AP
Telephone: 0121 685 4135 Email: roh.imaging@nhs.net

OFFICE USE ONLY

Date received: ______________

Appointment Date: ______________Time: __________

Rejected ☐ DNA ☐ Cancelled ☐

Comments: ______________________________

Examining Radiographer: ______________________