

For Office use:

**PRIMARY CARE OUT OF AREA RADIOLOGY REQUEST FORM**

**For use only when ICE electronic requesting is not an option**

**For X-ray - Please complete and give to patient to bring to Radiology Department. For other radiology please complete and email to: Frimley Park:** fhft.radiology.appt.authors@nhs.net, **Wexham Park:** Fhft.radiology.appointments@nhs.net

|  |  |
| --- | --- |
| Name of Patient’s GP: |  |
| GP National Code: |  |
| GP Practice name: |  |
| GP Practice Nat code: |  |
| Practice Address: |  |
| Tel: |  |

|  |  |
| --- | --- |
| NHS no: |  |
| Surname: |  |
| Forename: |  |
| Title: |  |
| DOB: |  |
| Address:  |  |
| Tel: |  |
|  NHS [ ]  Private [ ]  |

**REFERRER**

**PATIENT**

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| --- |
| Examination Requested: |
| Clinical Details: |
| Please advise if patient requires any additional support: Translator [ ]  Hoist [ ]  Lifting [ ]  O2 [ ]  Bed [ ]  Transport [ ]  Other [ ]  Please note:  |
|  |
| **Radiology Requestor Declaration**By making this referral I understand my legal responsibilities under IR(ME)R 2020 and confirm that * The correct patient details are given
* I have discussed the examination with the patient/responsible guardian
* I have taken into account the possibility of pregnancy
* I will ensure the results of this examination are recorded in the patient notes or electronic record
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| SIGNATURE **\*** | NAME | DATE |

Please click here for full details of our sites opening hours and contact details: [Radiology | NHS FHFT (fhft.nhs.uk)](https://www.fhft.nhs.uk/services/radiology/) **\*Unsigned request cannot be accepted and will be returned.**