StandingCT
Caring | Innovative | Ethical

Imaging Referral Form

Important Note: Examinations cannot be performed without completed Patient, Exam & Clinical Details, Referrer Signature and Date of referral (Ionising Radiation (Medical Exposure) Regulations 2017). All ***italic bold*** fields must be completed.
***Incomplete forms will be returned to the referrer for completion prior to booking patients.**

Patient Details		Appointment	
First Name	*	Date	
Surname	*	Time	
DOB	*	Location	
Gender	M / F / O	Self-Funding	Yes / No
Preferred Pronouns		Insurer	
Phone	*	Policy No.	
Email		Auth Code.	
Full Address (incl. post code)	*		

Exam & Clinical Details – CBCT scan request.			
Weight bearing Position	**Standing** ☐	**Sitting** ☐	**Other** (specify below) ☐
Laterality †	**Left** ☐	**Right** ☐	**Bilateral** ☐
Upper Extremity †	**Elbow** ☐	**Wrist** ☐	**Hand** ☐
Lower Extremity †	**Foot / Ankle** ☐	**Knee** ☐	**Hip** ☐
	Full Leg (No Gap) ☐	**Full Leg (Gapped)** ☐	

†Unless otherwise requested, images will be orientated to the laterality and anatomy of interest

Clinical Details

Accurate reporting relies on the provision of as much clinical information as possible. For lower extremities both sides will be scanned for comparison unless a single stance study is specifically requested.

All patients aged 12-55	
Could you be pregnant?	Yes / No
Signed	
Date	
N.B Additional information may be required at your appointment	

Referring Clinician		Imaging department use only	
Name	*	**Justified by**	
Qualification			
GMC Number	*		
Images to		**Signature**	
Report to			
Email			
Phone		**Vehicle / location**	
Referrer Signature	*	**Dose**	
Date of referral	*	**Date**	