Beacon Hospital

RADIOLOGY REQUEST FORM

Patient Details:
Male ☐ Female ☐
*MRN:

*Surname:

*Forename:

*Date of Birth:

Telephone:

*Address:

Doctors Details:
*Referring Doctor:

*Tel and Fax no:

Address:

***Signature:**

*IMC Number: Date:

Urgent ☐ **Routine** ☐

Previous exams
X-ray ☐ CT ☐ MRI ☐ US ☐ Mammo ☐ Dexa ☐ NM ☐ PET/CT ☐

OP ☐ IP ☐ Ward:

Walking ☐ Chair ☐
Stretcher ☐
Portable ☐ Theatre ☐
Breastfeeding Yes ☐ No ☐
LMP (date):

PRECAUTIONS: (Tick below if relevant):

IPC: Contact: ☐ Aspiration: ☐
Droplet: ☐ Supervision Required: ☐
Airborne: ☐

Falls Risk: Low ☐ Medium ☐ High ☐

***Examination Required:**

***Clinical History & Questions you need answered:**

MRI: Pacemaker ☐ Aneurysm Clips ☐ Intra-orbital metallic foreign bodies ☐

IV CONTRAST:
Previous contrast reaction: Yes ☐ No ☐ Diabetic Yes ☐ No ☐
Current medication (please tick): Oral Hypoglycemics ☐
Warfarin ☐ Aspirin ☐ Plavix ☐
Tick if appropriate: Kidney Dysfunction ☐
Bloods (Please tick): Creatinine ☐ **Coagulation:** Normal ☐ Abnormal ☐

Department Use Only:
Appt Date:

Time:

IV Contrast as per protocol? YES / NO
Radiologist/Dr Signature:

IMC Number:

STICK ADDRESSOGRAPH HERE

* Mandatory

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www.beaconhospital.ie