DIAGNOSTIC IMAGING REQUEST FORM

X-RAY	NUCLEAR MEDICINE
ULTRASOUND	MAMMOGRAPHY
CT	BONE DENSITOMETRY/DEXA
MRI	

Surname: ....

Forename: ....

Date of birth: ....

Patient number ....

Telephone number: ....

Sex: Male ☐ Female ☐

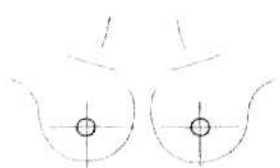
NHS/PCT ☐ Insured ☐ Self-pay ☐

High Road
Buckhurst Hill
Essex IG9 5HX

Tel: 020 8936 1202
Fax: 020 8936 1191
www.hollyhouse-hospital.co.uk

INPATIENT ☐ OUTPATIENT ☐ WALKING ☐ CHAIR ☐ TROLLEY ☐ PORTABLE ☐

Clinical Information



Investigation required:

Preferred Radiologist: Dr Pathak
(If applicable)

GP / Consultant's name and address (printed):

Signature: Date:

FOR DIAGNOSTIC CENTRE USE ONLY

JUSTIFICATION ☐ AUTHORISATION ________

RADIOGRAPHER / NO OF EXPOSURES

EXPOSURE FACTORS / METER READINGS.

For females aged 12 - 55 (if applicable to examination)

I am not pregnant ☐

L.M.P: ....

Signature: ....

Date: ....