Beacon Hospital

RADIOLOGY REQUEST FORM

Patient Details:	**Doctors Details:**
Male ☐ Female ☐	*Referring Doctor:
*MRN:	*Tel and Fax no:
*Surname:	Address:
*Forename:	***Signature:**
*Date of Birth:	*IMC Number: Date:
Telephone:	**Urgent** ☐ **Routine** ☐
*Address:	

Previous exams

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

OP ☐ IP ☐ Ward:	**PRECAUTIONS: (Tick below if relevant):**
Walking ☐ Chair ☐	**IPC:** Contact: ☐ Aspiration: ☐
Stretcher ☐	Droplet: ☐ Supervision Required: ☐
Portable ☐ Theatre ☐	Airborne: ☐
Breastfeeding Yes ☐ No ☐	
LMP (date):	**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:	**IV Contrast as per protocol?** YES / NO	
Appt Date:	Radiologist/Dr Signature:	STICK ADDRESSOGRAPH HERE
Time:	IMC Number:	

* Mandatory

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www.beaconhospital.ie