# Imaging Department Request Form

Issue March 2025 Review March 2028

NEW VICTORIA HOSPITAL

184 Coombe Lane West, Kingston upon Thames, Surrey, KT2 7EG
Telephone Enquiries: **+44 (0) 208 949 8578** Email: **imaging@newvictoria.co.uk**

Referring Clinician: _____

_____

Address: _____

_____

_____

_____

_____

Fax no. (for results): _____

Tel no.: _____

Surname: _____

First name: _____

Date of birth : _____

Address: _____

_____

Post code: _____ Tel no.: _____

Hospital no.: _____

Insurance company: _____

Policy no.: _____

**Clinical Information** (IRmER requires a full history):

**Patient Transport:**

| | | |
|---|---|---|
| **Inpatient** | ☐ | **Room no.** _____ |
| **Walking** | ☐ | |
| **Chair** | ☐ | |
| **Bed** | ☐ | |

| | | |
|---|---|---|
| **Allergies** | ☐ | _____ |
| **Asthmatic** | ☐ | |
| **Diabetic** | ☐ | |
| **Other** | ☐ | _____ |

**Examination(s) Required:**

| | |
|---|---|
| **Signature:** | **Date:** |

**I believe that I am not pregnant at the time of this examination.**

| |
|---|
| **LMP Date:** |
| **Signature:** |
| **Print Name:** |

## For Imaging Department Use Only

Appointment Information

| |
|---|
| **Date:** |
| **Time:** |
| **Print Name:** |

Contrast Information

| |
|---|
| **Name:** |
| **Time:** |
| **Lot No.:** |
| **Exp Date:** |

Radiographer Justification

| |
|---|
| **Initials:** |
| **Dose:** |
| **Date:** |