



Bath Imaging Partners LLP
RADIOLOGY REFERRAL FORM



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Patient Details (affix label if available)		Referrer Details	
RUH Number		Name	
NHS Number		Address for Report	
Surname			
Forename			
Date of Birth			
Address			
		Post Code	
		Telephone Number	
		Date	
		Referrers signature	
Post Code			
Telephone Number			
GP Name/ Practice			
Examination requested:			Known Allergies

Reasons for Referral /Clinical Details

After the referral form has been faxed [or E-mailed], the patient will be sent an appointment with all the necessary details about the scan. BIP appointments and appointment queries can also be made by phoning the relevant number below:

Ultrasound (01225) 825529

CT (01225) 825989

MRI (01225) 824072

Please allow time for the referral to be received and processed before phoning.

Examination Authorised By	Practitioner/Operator	Date
Practitioners Notes	Appointment details	
	Booked Admission Y/N	Appt Letter Sent
	Date Time	Date
	Transport Booked Y/N?	Appt Telephone
	Initials _____	Date
Patient ID Check	(Operator)	Date

Pregnancy Status (refer to department protocol and complete the following)

Patient Pregnant? Maybe/ Yes/ No LMP Date _____ Patient's Signature _____ Date _____

Examination justified by practitioner Yes/No Authoriser's Signature _____ Operator's initials _____

Breast Feeding Not Breast Feeding Checked by _____

Operator's Notes (including number of films for evaluation) <input type="checkbox"/>	Contrast Media / Drugs Administered
Operator(s) undertaking exposure _____	

EXAMINATION PROCEDURE	Exam	Room	Kvp	mAs	Dose/Activity	Screening Time