Cheshunt Alliance X-Ray

X-Ray Scan Request

Patient Details

Name: .....

Date of Birth: .....

Address: .....

.....

..... Postcode: .....

Tel no: ..... Mobile: .....

Email: .....

Male ☐ Female ☐ NHS No: .....
(Mandatory information)

Ethnic Group

White ☐ Mixed ☐ Asian ☐
Black ☐ Chinese ☐ Other ☐

Patient Source GP ☐ Private ☐

Clinical Details

Please give brief patient history & provisional diagnosis:

Please ensure that your patient does not have any metal splinters in their eyes, cardiac pacemaker, cerebral aneurysm clips, metal implants, or any other condition which contra-indicates MRI.

Areas to be imaged

BrainCervical	☐	SpineHip L/R	☐		☐
IAMsThoracic	☐	SpineKnee L/R	☐		☐
	☐	PituitaryLumbar	☐	SpineAnkle L/R	☐
	☐	OrbitsPelvisFoot	☐	L/R	☐
AngiogramSI	☐	JointsShoulder	☐	L/R	☐

Other (please specify)

Referring Clinician Details

Clinician's name: .....

Practice name: .....

Practice address: .....

Practice location code: .....

Telephone: .....

Fax / Email: .....

Referring Clinician's signature:

Date: .....

Safety

Weight (max 250Kg):

Serum Creatine Level:

AM00033|V2.0|Jul20

A partnership between the NHS and Alliance Medical

For General Enquiries:
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