Wrightington, Wigan and Leigh NHS Foundation Trust – X-Ray Department Referral Form

PATIENT DETAILS		GP DETAILS	
Name		**Referring Org.**	WIGAN GP ALLIANCE
DOB		**Referring Clinician Name:**	
Gender		**Patients GP Surgery:**	
Address		**Patients GP Surgery Address:**	
Tel No		**Tel**	
		Fax	
NHS No.		**Signature**	
Hospital No.	**Number**		
Email Address		**Date**	

Examination Requested

Clinical Summary (sufficient information to justify the procedure)

Ambulance	☐	Portable	☐	Consultant	
NHS	☐	Walk	☐	Ward	
CAT II	☐	Chair	☐	Previous X-Ray No.	
SEC. 58	☐	Trolley	☐	Pregnant	Yes ☐ / No ☐
Private	☐	Bed	☐	LMP	

? For contrast examination:

Diabetic	Yes ☐ / No ☐	**Authorised by & Instructions:**
On Metformin?	Yes ☐ / No ☐	
? Renal Impairment	Yes ☐ / No ☐	
Creatinine Requested	Yes ☐ / No ☐	**Appointment Time & Date:**
Or creatinine level & date	Yes ☐ / No ☐	

****This form Will Be Returned if Not Filled In Correctly & Signed By An Authorised Referrer ****

X-ray appointments, direct line telephone numbers:	**Leigh Infirmary**	**01942 264 207**	**Royal Albert Edward Infirmary**	**01942 822 397**
	Thomas Linacre Centre	**01942 774 608**	**Wrightington Hospital**	**01257 256 331**

IR(ME)R Requirements – The Operator must complete this section:

Patient identity confirmed	Yes ☐ / No ☐	Authorised Operator	
*Is or might the patient be pregnant?	Yes ☐ / No ☐	Assisted by	

*Females 12-50 years for examinations between diaphragm and upper femora and all Nuclear Medicine examinations

Films and Rejects

		Total	Reject	Reason
P	PACS			
	Hardcopy			
	18 x 24 Mammo			
	24 x 30 Mammo			

Contrast / Pharmaceutical Details: Affix labels

Injected by		Checked by	

Allergy Details:

Previous reaction to contrast	Yes ☐ / No ☐
Allergies	Yes ☐ / No ☐
Asthma	Yes ☐ / No ☐
Heart Disease	Yes ☐ / No ☐
Hay Fever	Yes ☐ / No ☐

Patient Radiation Dose Details:

Exposure/DAP/DLP	
Room	
Radionuclide & Dose	
Radiologist	

For X-ray Chest & Abdomen – Walk In 9am to 4pm
For other X-Rays please ring 01942 264207