CLINICAL IMAGING &
RESEARCH CENTRE

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The Wellington Hospital

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DUAL-SOURCE CT / NUCLEAR MEDICINE REQUEST

Patient Name:..... DoB: .....Hospital number X:..... Address: .... Post Code:…….. Contact Tel No:	**Referring Doctor**:..... Address for Results: Tel:..... Fax:.....
For females (12-55yrs): LMP date:..... **Could patient be pregnant? Y / N** Signed:	**Special requirements**: e.g. interpreters, oxygen, disability etc.

For In-patients only: □ Walking □ Bed □ Wheelchair Room Number:
□ Trolley □ Oxygen □ Nurse Escort ……..

Please indicate if patient is / has:

Diabetic and on Metformin	Y / N	Renal disease	Y / N
Asthmatic on inhalers	Y / N	History of Allergies	Y / N
		If yes, please state.....	

Clinical Information: Examinations cannot be performed without sufficient clinical information (Ionising Radiation Regulations 2000)

(What clinical question do you require answering?)

Examination(s) Required:

Nuclear Imaging:
□ Myocardial Perfusion Scan
□ MUGA scan

Dual Source CT:
□ Coronary Calcium Scanning
□ Dual Source CT Angiogram

Departmental use:
Radiology Appointment
Date: ...../...../.....
Time: .....

Departmental use:
Justified by:
Radiographer:
Date:
Dose:
Comments:

Doctors Signature: .....Date: ..../...../.....