DIRECT MEDICAL IMAGING Tel: 01253 640000 Fax: 01253 720027 **X-RAY REQUEST**

Surname Mr/Mrs/Miss	Referrer	Pregnancy Rule	Attendance Number
Forename (s)	Justified by / Practitioner	LMP / /	Date of Examination
Address		Is there a possibility of pregnancy? Yes No	(Office Use Only)
	Telephone	If the patient is/may be pregnant and you wish the examination to be performed, this box MUST be signed →	Doctor's Signature
Postcode	Date of Birth / /		

Clinical details. Please state the problem:	Radiology Use
	Radiographer / Operator
	KVp / mAS

Previous Operations	Results required for:-	Appointment
Examination Requested	Referrer's Signature	Day
		Date
Date Received	Date of Request / /	Time