

Patient details

Surname		GP	
First name		Practice	
Date of birth	Male <input type="radio"/> Female <input type="radio"/>	Address	
Tel home	Mobile	Tel	
Address		Insured Yes <input type="radio"/> No <input type="radio"/>	
Postcode		Self pay Yes <input type="radio"/> No <input type="radio"/>	
Insurers name			
Insurance number			

Relevant clinical details

Area to be scanned

	Urgent <input type="radio"/> Non-urgent <input type="radio"/>
	If urgent, date on which scan should be done by
	Relevant previous imaging
	Format of previous imaging Film <input type="radio"/> Digital <input type="radio"/>
	Date of previous imaging

Safety check

Does the patient have a cardiac pacemaker?	Yes <input type="radio"/> No <input type="radio"/>	If yes, can not have a scan. If no—proceed
Does the patient have an intracranial aneurysm clip / programmable ventriculoperitoneal shunt?	Yes <input type="radio"/> No <input type="radio"/>	If yes, can not have a scan. If no—proceed
Has the patient had a cochlear implant / neurotransmitter?	Yes <input type="radio"/> No <input type="radio"/>	If yes, can not have a scan. If no—proceed
Does the patient have renal impairment?	Yes <input type="radio"/> No <input type="radio"/>	If no then scan. If yes, then no intravenous contrast can be administered without Nephrologists opinion
Has the patient had any surgery in the last 8 weeks?	Yes <input type="radio"/> No <input type="radio"/>	If yes, can not have a scan. If no—proceed
Is there a history of metal foreign bodies in the patients eyes?	Yes <input type="radio"/> No <input type="radio"/>	If no—proceed. If yes, have ocular x-ray. If foreign body detected, no scan
Is the patient breastfeeding?	Yes <input type="radio"/> No <input type="radio"/>	If yes, no intravenous contrast can be administered
Is the patient pregnant?	No <input type="radio"/> Yes <input type="radio"/>	Stage <input type="radio"/> Month <input type="radio"/> If ≤ 4 months <input type="radio"/> no scan If > 4 months, the referring clinician should discuss with a Vista radiologist

Referring clinician's details

Referrer name	Email	
Specialty	Tel	Fax
Hospital / practice	How would you like to receive the report? Email <input type="radio"/> Post <input type="radio"/> Fax <input type="radio"/>	
Address	And the images? CD <input type="radio"/> Film <input type="radio"/>	
postcode	Do you want the report sent to another clinician? Yes <input type="radio"/> No <input type="radio"/> If yes give details	
Signature		Date