



Expert Eye

Tel: 0845 130 2918 Fax: 0845 130 2921

CT REQUEST FORM

Requestor details:

Name:

Address:

.....

.....

..... Postcode:

Contact Tel:

Signed:

Date:

Surname:

First Name(s):

Date of Birth:

Postal Address:

Tel: (H)

(W)

(Mob)

Invoice to be sent to:

Details must be filled in before request accepted.

CT report will be sent to the requestor above. If a copy report is required please give details below:

Name:

Address:

.....

.....

..... Postcode:

Clinical Details:

CT Investigation Requested (please tick):

- Brain
- Chest
- Abdomen
- Pelvis
- Other region (please specify)

.....

Does your patient have :

Asthma Yes No

Previous contrast reaction Yes No

Diabetes (on Metaformin) Yes No

Hx of Renal Impairment Yes No

FOR INTERNAL USE ONLY:

Request clinically justified or complies with IRMER protocol?
Signed _____ YES NO

Are you or might you be pregnant? YES NO N/A

Date: _____ Patient Signature: _____

PROTOCOL:

Patient identification verified and pregnancy status checked?

Signed _____

Signed: _____

Consultant Radiologist

Date: _____

CONTRAST IV IA IT	Dose mls	Time	Sig	Dose	
Iopamidol 300 (Niopam)				kV	
Iodixanol 270 (Visipaque)				mAs	
Gadodiamide (Omniscan)				DAP	
Gastrografin/ Water	None	1/2hr	1hr	Screen time	