



# Expert Eye

Tel: 0845 130 2918 Fax: 0845 130 2921

## X-RAY 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.

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

Name: .....

Address: .....

.....

.....

..... Postcode: .....

### Clinical Details:

### X-ray Investigation Requested (please tick):

Chest

Extremity (please specify) .....

Other region (please specify area) .....

### 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: \_\_\_\_\_

EE ID No:

Appointment Date/Time:

Dose	
kV	
mAs	
Screen time	