

**IMAGING REQUEST FORM (for GPs)
Whipps Cross Hospital**

Please complete all sections. Incomplete forms may be returned for completion.

**REQUESTS MUST BE SIGNED BY THE REFERRING DOCTOR.**

**1. Procedure**

 **X-Ray**

 **Clinical information and reason for request**

Examination requested:

Is there any possibility that the patient is pregnant? Yes/No\*

Does the request conform to RCR guidelines? Yes/No\*

**Date of request (required): Please note:** This

 form is only valid for

 three weeks from the

 referral date. Older

 forms will not be

**2. Patient details** accepted

Hospital ref: …………………………………………

NHS number: ………………………………………… Address: ……………………………………

Surname: ………………………………………… ……………………………………

First name: ………………………………………… Gender: …………………………………………..

Date of birth: ………………………………………… Phone: ……………………………………

**3. GP details**

GP name: ………………………………………… Practice name and phone number / practice stamp

Signature: …………………………………………

Email address:…………………………………………

Practitioner’s Number:

**Information for Patients and GP**

**A walk in service is available for acute referrals:**

* **X-Ray walk-in service open: Monday – Friday 9am to 12pm**

**Appointments are available for routine referrals:**

* **X-Ray appointments only: Monday – Friday 9am to 4pm**

To book your appointment, you can either email the completed request forms to **bartshealth.gpappointment@nhs.net** or
call to arrange an appointment on Tel**: 02077673323 Option 4**For any other queries please call on Tel: **02077673323 ext.5520** Lines are open **Monday to Friday 9am – 5pm**