QUEEN SQUARE IMAGING CENTRE

Queen Square Imaging Centre
8-11 Queen Square
London
WC1N 3AR

020 7833 2513
020 7837 8074
www.queensquare.com

Computed Tomography (CT) Referral Form

Please complete this form with all known details and return by fax to 020 7837 8074 or by email to imaging@queensquare.com.

Patient Details

Title: **Please select**
Surname:
Forename:
Date of Birth: / /
Mobility: **Please select**
Is the patient? : **Please select**
Insurance Details (If applicable)
Medical Insurer Name:

Hospital Number:
Address:

Postcode:
Telephone:
Email:

Membership Number:

Examination/Procedure

Examination Requested:
Relevant Clinical Details:

CT Clinical Checklist:
eGFR Result: on: / /
Date of LMP: / /

For CT examinations that involve irradiation of any region between the diaphragm and knees, patients must be within 10 days of the 1st day of their last period.

Is the patient Diabetic? ☐ Yes ☐ No

Does the patient have any known allergies? (please provide details) ☐ Yes ☐ No

Have any previous scans been uploaded to PACS or sent to the Imaging Centre for review? ?

Referral Details

Referrer Name:
Referrer GMC Reg:
Report and CD to be returned to:

Signature of Referring Clinician:

Date of Request: / /

Queen Square Imaging Centre Staff Use:

QSIC Patient Number:
Appointment:

Billing:
Radiographer Initials: