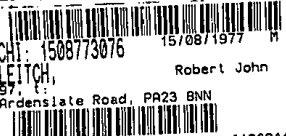
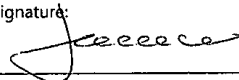


* The Ionising Radiation (Medical Exposure) Regulations 2000 IR(ME)R require you to complete all this information accurately. Shaded Areas are for imaging department use. Incomplete/ illegible forms may be returned. **Please read overleaf prior to completion.**

 CHI: 1508773076 15/08/1977 LEITCH, Robert John 57, t: Ardenslate Road, PA23 8NN Dr D. Chant, The Surgery, PA23 8BG 03/02/2023 14:35. Practice: 84241 4186841		Referring Consultant/GP: Jomkuanie Ward/Clinic/Practice: STURUM ST. Phone (day and evening): 07383 443 420	Appointments:
Investigation(s) requested: ULTRASOUND TESTICLE		Please complete for all outpatients Is this a New Diagnosis? ☒ Tracked patient? YES ☐ Is this a Planned Procedure? ☐ NO ☐ Result required by MDT/Clinic on: ☐ Date:	
Clinical summary (to include indication and purpose of examination/intervention under IR(ME)R 2000*): What is the clinical question? (Please PRINT boldly in black ink) Swelling lower pole left testicle and upper pole right testicle ? testicular Pathology		IR(ME)R Justification: YES ☐ NO ☐ Date received: Preparation: Fast: Full bladder: Laxative: Oral contrast: No prep: Urgency: Initials: Examination protocol:	
Please indicate any previous surgery or history of malignancy?			
TO BE COMPLETED BY REFERRING CLINICIAN			
Safety information required for all patients requiring IV or IA contrast medium CT/MRI/DSA/IVU/ Intervention For contrast studies a recent eGFR is mandatory. (See note 4 overleaf). Current eGFR: Date of result:		Additional information for MRI patients Please indicate if patient has any of the following: Yes No A cardiac pacemaker? ☐ ☐ Surgery in the last 8 weeks? ☐ ☐ Aneurysm clipped/treated? ☐ ☐ Metal fragments in eyes? ☐ ☐ Previous cranial surgery? ☐ ☐ Any metal in the body? ☐ ☐ Claustrophobia? ☐ ☐	
Is your patient diabetic? Yes ☐ No ☐ If so, does your patient take metformin? (see note 5 overleaf) Yes ☐ No ☐ Has your patient had a contrast medium injection before? Yes ☐ No ☐ Does your patient have a known contrast medium allergy? Yes ☐ No ☐ Does your patient have severe or multiple allergies? Yes ☐ No ☐ Does your patient have asthma? Yes ☐ No ☐		This patient has no risk factors and can proceed to contrast medium without eGFR. Initials: OR For interventions a coagulation screen is required in certain scenarios – see overleaf for details. For any interventions (see note 7 overleaf): Is your patient on anticoagulants? Yes ☐ No ☐ Current INR/coagulation score:	
Pregnancy Rule Observe: ☐ Ignore: ☐ Specify:	AT RISK MRSA: ☐ C Diff: ☐ Specify:	Transport GP/Out-patients Walking with assistance (suitable for hospital car) ☐ Uses own wheelchair ☐ Stretcher ☐ Escort required (must have medical need) ☐	Transport/In-patients Trolley: ☐ Chair: ☐ Oxygen: ☐ Drip: ☐
Referrer's declaration: (NB: This form is a legal document under Ionising Radiation Medical Exposure Regulations 2000) • I certify that the correct patient details have been given • I have discussed the examination requested above with the patient, his/her parent or guardian • I have taken into account the possibility of pregnancy • I have given sufficient information for the request to be justified according to IR(ME)R 2000 • I will ensure that the results of the examination are recorded in the patient's notes • I know of no contraindication to performing the examination or intervention I have requested			
Referrer's signature: 	Name: Jomkuanie	Designation: Lower GP	Date: 3.2.23