Blackrock Clinic Nuclear Medicine Dept.
Tel 283 2222 Ext 3021

Request Form

SURNAME FIRST NAME ADDRESS		ROOM NO	CLINIC	EXT
HOSP NO	TEL NO	LMP DOB		PREVIOUS X-RAYS ☐ PREVIOUS NM SCAN ☐

Nuclear Medicine Laboratory Tests

- ☐ ^{14}C Urea Breath Test (*Helicobacter Pylori*)
- ☐ ^{99m}Tc DTPA GFR (*Renal function*) -2 bloods, no urine collection-
- ☐ Double Schilling Test (*Pernicious Anaemia*)

Radionuclide ('Isotope) Scans

TYPE ________________________________

CLINICAL DETAILS:

INJ. + ACT ______________
INJ. TIME ______________
INJ. BY ______________

Date of Request	Referring Doctor (print)	Signature of Referring Doctor

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