BLACKROCK HEALTH

BLACKROCK CLINIC

Freephone: 1800 300 200
Fax: +353 206 4368
Email: radiology@blackrock-clinic.com

PATIENT DETAILS

(Please Print)

Name: ______________________________ Date of Birth: _____/_____/_______

Address: ____

Phone: ________________________ BRC MRN: ____________________

ED: ☐ GP: ☐ CON: ☐ IN-PATIENT: ☐ Ward: _______ Room: _______

Appears at risk of falling: ☐ Patient Infection Status: ______________________

Previous Imaging in BRC: Yes ☐ No ☐ Pacemaker or ICD: No ☐ Yes ☐ Details __________

Health Insurance: Yes ☐ No ☐ Insurer ______________ Policy No: ______________

Public Patient : Yes ☐ No ☐ Hospital PO /UAN number: ____________________

Imaging Required: MRI ☐ CT ☐ US ☐ X-ray ☐ Nuc Med ☐ PAC ☐

Examination Required: ____

Clinical Indication: ____

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Scan required: Urgent ☐ Next available ☐ Future date (please specify):_______________

Referrers Signature: _________________________ Reg No: ___________________

Referrers Name: _____________________________ Date: ___________________

(Please Print)

Referring Consultant: _____________________ Referring Hospital: _________________

Address for Report: ____

RADIOLOGY USE ONLY

RADIOGRAPHER:	DOSE METRIC:	DATE:

PLEASE ENSURE THE REQUEST FORM IS FULLY COMPLETED, SIGNED AND DATED

INCOMPLETE REQUESTS WILL NOT BE ACCEPTED AND WILL CAUSE PATIENT DELAYS