# Blackrock Clinic

Imaging Department

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: _____

IN-PATIENT: Yes ☐ No ☐ Ward: _____ Room: _____ ED: ☐ GP: ☐ CON: ☐

Previous Imaging in BRC: Yes ☐ No ☐

Imaging Required

| MRI | CT | US | X-RAY | NUC MED |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

Insurance: Yes ☐ No ☐ Insurer: _____

PAC: ☐ Day Case: ☐ Portable: ☐ Chair: ☐ Walking: ☐ Stretcher: ☐

Examination Required: _____

Clinical Indication: _____

_____

_____

What clinical question should this examination answer: _____

*Referrers Signature: _____ Reg No: _____

Referrers Name: _____ Date: _____

(Please Print)

Address for Report: _____

**RADIOLOGY USE ONLY**

| RADIOGRAPHER: | DOSE METRIC: | DATE: |
|---|---|---|

**ADMINISTRATIVE USE ONLY**

| COVID-19 QUESTIONNAIRE COMPLETED<br>No Issue ☐ Issue ☐<br>COMPLETED BY: _____<br>Date _____ Time _____ | LMP: | Fall Risk: Yes ☐ No ☐<br>Patient Infection Status: |
|---|---|---|
| | | |

**PLEASE ENSURE THE REQUEST FORM IS FULLY COMPLETED AND *SIGNED. INCOMPLETE REQUESTS WILL NOT BE ACCEPTED©**