BLACKROCK HEALTH

HERMITAGE CLINIC

Email: radiology@hermitageclinic.ie

PATIENT DETAILS

(Please Print)

Title: _____ First Name: _____ Surname: _____

DOB: _____/_____/_____ Sex: _____ MRN: _____

Address: _____

Phone: _____ Email: _____

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

Patient Infection Status: _____ Pacemaker / ICD: Yes ☐ No ☐ Details _____

Falls Risk Score: _____ Bed ☐ Chair ☐ Walking ☐ Portable ☐

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

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

Interventional Radiology - Sample Required: YES ☐ NO ☐ INR: _____ FASTING: YES ☐ NO ☐

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

Examination Required: _____

Clinical Indication: _____

_____

_____

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

Referrer's Name: _____ IMC no: _____

(Please Print)

Referrer's Signature: _____ Date: _____/_____/_____

Referrer's Address: _____

(If outpatient)

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