THE LISTER HOSPITAL
chelsea

part of HCAHealthcare UK

Non-Invasive Vascular Imaging Request Form

PATIENT DETAILS		IMAGING APPOINTMENT DETAILS	
TITLE	SURNAME	DATE	TIME
FORENAME		REFERRING DOCTOR	
DoB:	X No	ADDRESS FOR RESULTS;	
ADDRESS		TEL NO :	
Patient Contact No:		FAX NO:	

Clinical Indications

Authorised Signature .... Date of Request....................................

Examination Required	RIGHT	LEFT	BILATERAL
Full DuplexVenous - Lower Limb			
Post Op Check - Lower Limb			
Deep Vein Thrombosis (DVT) Lower Limb			
Ful Arterial - Lower Limb			
Other Examination Required - Please specify			
Carotids			
ABPI			
ABPI with Treadmill			

Vascular Scientist	Date of scan	Office Use Only

Please fax completed form to +44 (0)20 7259 0138 or email to lister.imaging@hcahealthcare.co.uk
For Imaging appointments, results and enquiries, call +44 (0)20 7730 3759

Guidance Notes for Referrers

Referrals:

- A request for a radiological examination will be regarded as a request from one clinician or health professional to the Radiology Department for an opinion based upon a radiological examination to assist in the management of a clinical problem.
- Diagnostic imaging or radiological procedures will only be performed upon a written request signed by a registered medical or dental practitioner or by an authorised non-medical practitioner.
- Referrals (request form or letter) must precede or accompany the patient. Faxes and emails are accepted.
- All requests must carry sufficient information to identify the patient. This normally consists of first name, middle name if any, and family name, date of birth and address.
- All requests shall clearly state the examination requested.
- All requests must include contact details of the referring clinician including address and telephone number.

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