Spire
Portsmouth Hospital

spireportsmouthdiagnosticimaging@spirehealthcare.com

Imaging request	
CT	MRI
X-ray	Ultra sound

Patient details:	
Surname:	
First name:	
Hosp number:	Dob:
Address:	
Town:	
Postcode:	

Contact details:	
	Preferred
Home:	
Mobile:	
Work:	
Email:	

Please be aware that standard email is not secure or confidential

Examination requested:
Date requested:
Urgent / routine / specify:

Previous relevant radiology and location:		
Nature	Date	Location

Clinical information and clinical question:	
Question to be addressed:	PTO for diagram:

Specific radiologist requested:

Special requirements:	
Mobility: Yes No	Communication: Yes No
Elevated BMI:	
Other:	

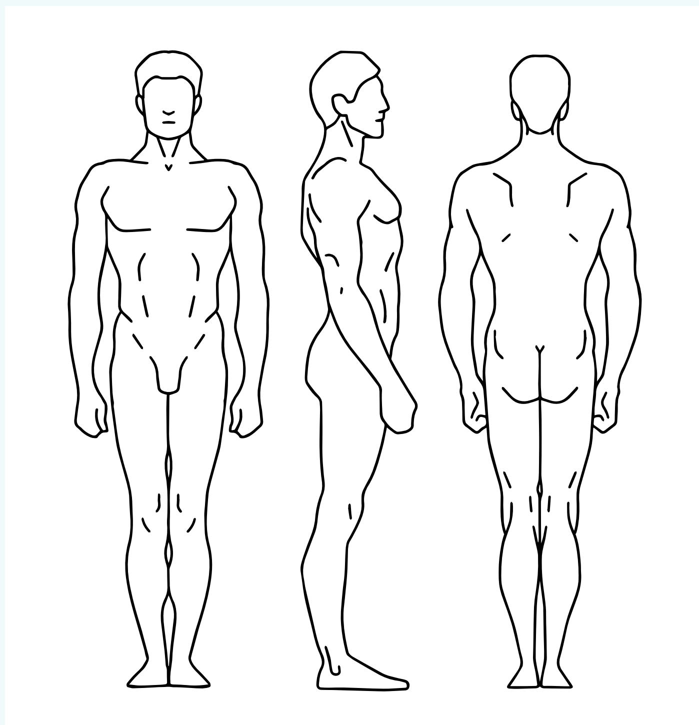
Other information:

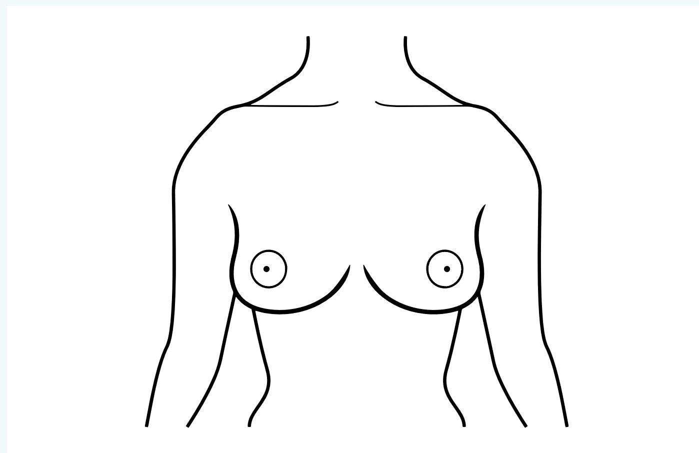
Blood tests:	
(For CT & MRI scan with contrast the following blood tests are required within a year of the examination.):	
eGFR:	Creatine:
Date:	Location:

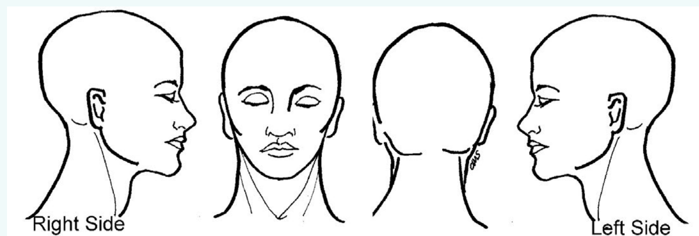
LMP:

Referring clinician:	Signature:
Address for reports:	Date:

Please indicate position of lesion:







CT Colonoscopy

Scans will not be performed if not completed in full by the referrer.

Has a rectal exam been performed? Yes No

Does the patient have:

Any known allergies?

Any known contraindications to Gastrograffin?

Any known contraindications to Buscopan?

Consultant Signature:

Date:

Additional comments:

For radiology department use

For self funding patients please provide a quote before booking an appointment

spire.portsmouthimaging@nhs.net (if other email must be encrypted)

Reception Tel: 023 92 456 040