

Imaging Request Form

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DXA 

MRI 

X-Ray 

Surname: Forenames: Title:
 DOB: NHS Number: Male: Female:
 Address:
 Post Code:
 Tel No: Home Work Mobile

Examination Requested: NHS  PP 
Please indicate if this patient may be pregnant Yes/No
 Clinical Details (For DXA see reverse):

Referring Consultant/GP:

Signature: Name: Date:
 Address for report:

Radiographer use only

RIS Number:
 Signature: Radiation Dose Cy/Cm²:
 Number of Images:

Office use only

Appointment Date: Appointment Time: Authorisation :
 Non-NHS Payment Details:

Medical History

* Alcohol Misuse	<input type="checkbox"/>	Yes	* Rheumatoid Arthritis	<input type="checkbox"/>	Yes
* Cancer (inc Myeloma)	<input type="checkbox"/>	Yes	* Longterm use of Steroids >3months	<input type="checkbox"/>	Yes
* Aromatase Inhibitors	<input type="checkbox"/>	Yes	* Hysterectomy <45 years	<input type="checkbox"/>	Yes
* Chronic Liver Disease (inc dialysis/transplant)	<input type="checkbox"/>	Yes	* Oophorectomy	<input type="checkbox"/>	Yes
* Eating Disorders	<input type="checkbox"/>	Yes	* Amenohorrea	<input type="checkbox"/>	Yes
* Hyperparathyroidism	<input type="checkbox"/>	Yes	* Premature Menopause <45 years	<input type="checkbox"/>	Yes
* Hyperthyroidism	<input type="checkbox"/>	Yes	* Family History of Osteoporosis	<input type="checkbox"/>	Yes
* Hypogonadism	<input type="checkbox"/>	Yes	* Maternal History of Hip Fracture	<input type="checkbox"/>	Yes
* Malabsorption/Malnutrition	<input type="checkbox"/>	Yes	* Depo-provera	<input type="checkbox"/>	Yes

Spontaneous fracture/s: Vertebral Deformity: Osteopenic x-ray:

Site: Loss of height:

Date of last DXA scan:

Current Drug Treatment

	Details	Years
<input type="checkbox"/> Bisphosphonates	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Calcium Supplement	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> HRT	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Steroids	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Other (please specify)	<input type="text"/>	<input type="text"/>

A bone density (DXA) scan or x-ray is not recommended if you are pregnant.
 I hereby certify that, to the best of my knowledge, I am not pregnant.

Signed: Date:

Name: Radiographer: