Doughiska, Galway, Ireland
Phone: (091) 785 600
Appointments: (091) 785 554
Reports: (091) 785 628
Fax: (091) 785 604

Organization Accredited by Joint Commission International

RADIOLOGY REQUEST FORM

Date Requested ______________________

PATIENT DETAILS:

Name: ______________________

Date of Birth: ______________________

Address: ______________________

____

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Tel/Mobile Number ______________________

EXAMINATION/PROCEDURE:

- ❑ X-Ray/Fluro (We provide a walk in service for X-ray)
- ❑ Ultrasound
- ❑ CT
- ❑ Nuclear Medicine
- ❑ MRI
- ❑ PET/CT
- ❑ Mammo (If the patient has symptoms please refer to a breast surgeon. We offer a walk in service for asymptomatic patients over 40 years.)

REFERRING DOCTOR DETAILS/STAMP:

Name ______________________

Address ______________________

____

____

Signature ______________________

Tel/Mobile Number ______________________

Fax Number ______________________

Would you like the report faxed / emailed ❑ Y ❑ N

Enter email: ______________________

Examination(s) Requested:

Relevant Clinical Details:

Diagnosis to be excluded:

For all studies involving x-rays in women of child bearing age.
I am aware that the Galway Clinic adheres to a 10 day rule for diagnostic imaging procedures involving ionizing radiation for female patients of child bearing age (12–55 yrs).

LMP (dd/mm/yy): ______________________

- ❑ **I wish that the 10 day rule apply even if this means rescheduling the procedure.**
- ❑ **I require that a pregnancy test be performed and is negative before proceeding.**
- ❑ **I wish that the procedure be performed regardless on the basis that the clinical benefits outweigh any potential risks.**

If no box is ticked the Department will revert to the 10 day rule policy.

Requested by: ______________________
Doctors Signature

Date: ______________________

Further request forms available at

www.galwayclinic.com