



Nuclear Medicine Service

Glenfield Hospital
(0116) 258 3850Leicester Royal Infirmary
(0116) 258 5627

NUCLEAR MEDICINE REQUEST

Unit No.....NHS/PP Surname.....M/F First Name..... Address..... D.O.B..... Patient's Phone No(s) Ward/Clinic..... Clinic return date..... Consultant..... Practice/Hospital: Referral type: Urgency: Primary diagnostic D Routine D Follow-up D Clinically Urgent D Surveillance D Please give specific Planned D reason:..... Research D 	Please indicate any pathway patient is on: RTT ☐ Cancer 62 day ☐ Other: Breach date:...../...../..... Patient Weight.....kg In patients: Trolley / Chair / O ₂ Out patients: Ambulance/Car required? Yes / No Infection Control Risk? Yes / No Could patient be pregnant? Yes / No Is the patient breastfeeding? Yes / No Known allergies? Latex Yes / No Other (please list)
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INVESTIGATION REQUIRED:

Clinical details (including reasons for the test):

Signature..... Print name.....

Job title Bleep..... Date.....

Radioiodine Therapy Therapy prescription..... MBq Changes in medication required: Changes to standard restrictions:	Trial patients: Trial name: Study investigator: Patient ID number: Consent obtained? ☐ Written information given? ☐
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OFFICE USE ONLY

CRIS number
Previous NM scans

Appointment date and time

App 1	App 2	App 3
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UHL NHS Trust - Nuclear Medicine Service IRMER and Patient Checks

AUTHORISATION

Authorised by (signature and date):	
ARSAC Certificate Holder (if not above)	
Special instructions:	
Study Code:	

Is this a referral under a current research trial?	Yes/No
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CARDIAC

Exam code	NMTFS	NCARE	MCSPS
Priority	Urgent	Standard	Suspend
List	Supervised	Non-supervised	
Drug	Adenosine	Dobutamine	

RADIATION PROTECTION ADVICE

Therapies only:

Radiation protection advice given?	Y/N
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I can confirm that I have received written radiation protection advice	
Sign	
Print	
Date	

EXTRA CHECKS TO PERFORM ON DAY OF EXAM

PRE ADMIN MEDICATION MEDICATION AND INITIALS		
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POST - PROCESSING INFORMATION

Operator			
Time in			
Time out			

OPERATOR CHECKS AND INFORMATION

PATIENT ID (PLEASE INITIAL)

Delete as appropriate:	Name	Address	DOB	Wristband
1	Admin			
2	Admin/scan			
3	Admin/scan			
4	Admin/scan			

PREGNANCY AND BREASTFEEDING

I can confirm that I am not: pregnant 🐼 breastfeeding 🐼	
Sign	
Print	
Date	

PERSON CONFIRMING IDENTITY (IF NOT THE PATIENT)

Delete as appropriate:	Name (please sign)	Relation/Designation
1	Admin	
2	Admin/scan	
3	Admin/scan	
4	Admin/scan	

PATIENT WEIGHT

Date	Weight (kg)

	1	2	3
Date			
Radiopharmaceutical/Drug			
Batch Number			
Activity (MBq)/Dose			
Injection site			
Via			
Time			
Checker			
Administrator			