NHS Birmingham and Solihull Integrated Care Board

NHS University Hospitals Birmingham NHS Foundation Trust

CT KUB RENAL COLIC IMAGING REFERRAL FORM

PATIENT DETAILS		REFERRER DETAILS	
Name:		**Usual GP:**	
Address:		**Practice Address:**	
Postcode:		**Practice Code:**	
NHS Number:		**Practice Phone No:**	
Hospital number:		**Practice Email:**	
Date of Birth:		**Name of Referrer:**	
Referral date:		**Referrer Mobile No:**	
		Referrer Role:	
Special Needs:	☐ Capacity to consent ☐ Sight ☐ Hearing ☐ Oxygen ☐ Barrier ☐ Interpreter Language:	**Mobility :**	☐ Walk ☐ Chair ☐ Bed ☐ Mobile imaging req. ☐ Escorted

Preferred Contact No:	**Home:**		**Work:**		**Mobile:**	

Patient consents to be contacted by text message?: ☐ Yes ☐ No

Preferred Hospital: QEHB ☐ Heartlands ☐ Solihull ☐ Good Hope ☐

Procedure or Examination requested:	**Patient Medical Status**	
	Allergies:	
	Pregnancy:	☐ Yes ☐ No
Clinical Question and Relevant Information:	**Breast Feeding:**	☐ Yes ☐ No
	Asthmatic:	☐ Yes ☐ No
	Diabetic:	☐ Insulin ☐ Metformin
	Exams requiring contrast:	☐ U&E Test Underway eGFR:
	MRI use only (Please tick if the patient has the following)	
	☐ Pacemaker	☐ Aneurysm clip
	☐ Metal foreign Body	☐ Operation within 3/12

Click here for current imaging referral guidelines: https://www.uhb.nhs.uk/gps/referrals/imaging/

OFFICE USE ONLY

Imaging Notes	***Imaging Audit Data***	
	Received Date:	
	Operator:	
	Signature:	

As CT KUB is a high dose procedure, please ensure that the radiation dose is considered before requesting the scan.

Diagnostic procedure	Typical effective dose (mSv)	Equivalent number of chest X-rays	Approx. equivalent period of natural background radiation
Chest (single PA)	0.015	1	2.5 days
Abdomen	0.4	30	3 months
Intravenous urogram (IVU)	2.1	140	11.5 months
CT head	1.8	130	10 months
CT kidneys, ureters, bladder (KUB) (for renal stones)	6.5	460	3 years

REQUEST FOR CT KUB : (All of the following criteria must be fulfilled for the referral to proceed)

PATHWAY CHECK LIST: (Please tick to confirm that all criteria have been met)

☐ **Face 2 Face GP consultation,** **Date of consultation**

☐ **Classic loin to groin pain less than 7 days** **Left / Right /Bilateral**

☐ **Microscopic haematuria >2+**

☐ **No CT KUB in the previous 6 months**

☐ **Patient not pregnant*** **LMP Date ______________________________**

*Recommend US including pelvic US rather than CT for females of child bearing age.
*If LMP is below 7 days CT KUB can be carried out (Allowing 2-3 days for us to book the scan).
*If LMP is greater than 7 days, please provide a pregnancy test result along with the request and ask patient to abstain from sex / protected sex.
*Pregnancy Disclaimer form to be signed by patient on arrival.

Referrer Declaration – Please confirm and tick

☐ GP Direct Access Pathway referral criteria completed above
☐ Email header states the request is Urgent
☐ The patient is aware that they may be offered the first available appointment at any of the UHB sites
☐ I understand that failure to complete the form correctly will result in rejection and the form being returned

Referrer signature: **Date:**
(If form manually completed)

Please submit your completed referral form to the following email inbox based on your patient's preferred hospital **stating in the email header** that the request is **Urgent**

Hospital	Email
Queen Elizabeth Hospital	CT-Bookings@uhb.nhs.uk
Heartlands Hospital	BHHImagingreferrals@uhb.nhs.uk
Solihull Hospital	SOLImagingreferrals@uhb.nhs.uk
Good Hope Hospital	GHHImagingreferrals@uhb.nhs.uk

IT IS VITAL AN NHS DOMAIN EMAIL IS INCLUDED IN THE REFERRER DETAILS. This will allow us to send urgent but non critical findings (i.e. suspected cancer) for your attention. Failure to include an appropriate email will result in the form being returned.