TotalBalance
Wellbeing Centre

GETTING LIFE IN BALANCE

EXTERNAL X-RAY REQUEST FORM

We offer this service to other practitioners within our community who do not have their own X-ray facilities. Our service works as follows

1) You the practitioner contact us by completing this side of our form and including cheque made out to "Total Balance Wellbeing Centre Limited" for a payment of £75 per X-ray series needed. (by a series we mean a cervical series or a lumbar series for example)
2) We contact your patient directly to arrange an appointment for the X-ray to be taken asap.
3) We get our external consultant radiologist to produce a full report on the x-ray findings
4) We produce a disc containing X-ray images both in JPEG and DICOM formats along with the PDF X-ray report.
5) We contact you to arrange collection. This is usually within 7 days of the x-rays being taken.

Section 1 - Requesting practitioner's details

Name:	Telephone:
Postal Address:	Email:
Signature: Date: **NOTE, BY SIGNING, YOU ARE 1) AGREEING TO THE TERMS OF OUR SERVICE ABOVE. 2) AGREEING THAT ALL THE INFORMATION YOU ARE PROVIDING IS TO THE BEST OF YOUR KNOWLEDGE COMPLETE, ACCURATE AND TRUE.**	

Section 2 - Patients details

Full Name:	Sex: Male / Female
Date of Birth:	Daytime telephone number:
Postal Address:	

Section 3 – Medical information

History of chief complaint:
Other Pertinent History, Exam, Laboratory or Imaging Findings:
Working diagnosis:
X-Ray views requested: ☐APCx ☐LatCx ☐OblCx ☐APOM ☐Shlr ☐LatTh ☐APTh ☐OblTh ☐APLx ☐LatLx Other ______________________________

19 -21 SURREY STREET, LOWESTOFT, SUFFOLK, NR32 1LJ.
TEL: 01502 517070 **FAX**: 01502 517074
EMAIL: INFO@TOTAL-BALANCE.CO.UK **WEB**: WWW.TOTAL-BALANCE.CO.UK
UK REGISTERED OFFICE FOR COMPANY NO. 05942009

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SIDE TWO - TO BE COMPLETED BY THE RADIOGRAPHER.

Section 1 – Radiographers details

Name:
Date exposures taken:

Section 2 – Clinical justification met by patient for x-rays to be taken

☐ 50+ ☐Tra ☐Neu ☐UWL ☐Art ☐Mal ☐Ste ☐Pyr ☐Sco ☐Sur ☐FTI

☐ EBF ☐IEP ☐ELP ☐DAA ☐ Other ____________________________________

Section 3 – X-Ray views actually being taken

☐APCx ☐LatCx ☐OblCx ☐APOM ☐Shlr ☐LatTh ☐APTh ☐OblTh ☐APLx ☐LatLx

Other ____

Section 4 – Patient information and declaration

Name:
Date of Birth:
X-ray Computer number:

Declarations:

I the patient declare that I .....

- Have read the risks of radiation handout.
- Have had the following X-rays in the last 12 months_________________________ / ☐ NONE
- Am not pregnant or if I may be pregnant, I have had the risks of X-ray radiation in pregnancy explained to me, and the reason why an X-ray examination is necessary for my treatment, and I hereby give consent to be X-rayed as indicated above.

Patient Signature: ____________________________ Date: __________________