POWYS TEACHING HEALTH BOARD

LLANDRINDOD HOSPITAL

RLQ

Powys/000006

X-RAY

Surname ..... Hosp. No. .....
Mr./Mrs./Miss

First Name ..... Date of Birth .....

Address .....

.....

.....

Telephone No. .....

Occupation .....

ADDITIONAL INFORMATION:

CLINICAL DETAILS	L.M.P.	IS EXAM TO BE TIMED WITH MENSES YES/NO

PATIENT MOBILITY: Please tick all Relevant boxes

Walk Trolley
Bed Chair
Escort Yes/No
Risk Assessment **A /B//C//D**

Date ..... Signature of Referrer .....

Print Name

Justified By	
Dose: c.Gy * cm^2	
PATIENT I.D. CHECKED	RADIOGRAPHER'S SIGNATURE

Ward/Dept

EXAM REQUESTED

PROSTHETIC HEART VALVE : YES/NO