DIGITAL IMAGING

PATIENT DETAILS and CONSENT FORM

Name .....

Date of birth .....

Address .....

.....

Tel .....

Mobile .....

Email .....

For Female patient only (tick one)**:**

☐ I am not pregnant. Date of last period .....

☐ I may be pregnant. I have had the risks of radiation in pregnancy explained to me and the reason why an x-ray examination is necessary for my treatment. I agree to a pregnancy test before examination

Signed ..... Date .....

Consent: I am the patient and agree to an authorised person at Beeston Chiropractic Clinic Ltd to perform a radiological examination on me as requested by my Health Care Practitioner (see over).

I understand that the images remain the property of my Health Care Practitioner in accordance with the code of practice issued by the General Chiropractic Council.

However, I may ask for their release with my consent to other Health Care Professionals.

Signed ..... Date .....

Appointment details

Signed ..... Date .....

Cost quoted £ .....

Payment strictly on completion by cash or most major debit/credit cards

VISA MasterCard

BEESTON
CHIROPRACTIC CLINIC

For office use only

Referring practitioner

Name .....

Profession .....

Clinic Address .....

.....

Telephone number .....

Email .....

I have made a clinical decision to request x-rays of

..... following a clinical examination.

Signed .....

Date .....

The patient meets the following criteria justifying this request for x-ray:

50+	Tra	Neu	UWL	Art	DAA	Mal	Ste
Pyr	Sco	Sur	FTI	EBF	Pos	LEP	

Please take the following images of this patient: (Area and orientation)

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Notes

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BEESTON
CHIROPRACTIC CLINIC