East Sussex Healthcare
NHS Trust

FOI REF: 25/612

Eastbourne District General Hospital
Kings Drive
Eastbourne
East Sussex
BN21 2UD

Tel: 0300 131 4500
Website: www.esht.nhs.uk

1st October 2025

FREEDOM OF INFORMATION ACT

I am responding to your request for information under the Freedom of Information Act. The answers to your specific questions are as follows:

We would ask for your NHS Trust to provide information on two aspects:

1. **Whether safety screening forms or checklists which are completed by patients prior to a diagnostic imaging examination are in paper form or in digital format (e.g. web-based or tablet)?**

   This includes but may not be limited to:

   - **Inclusive Pregnancy status (IPS) or last menstrual period (LMP) forms**
   - **Magnetic resonance imaging (MRI) safety forms**
   - **Contrast media administration (all modalities)**
   - **Bone densitometry (DXA) patient questionnaire**
   - **Any other examination-specific forms e.g. CT colonography or cardiac questionnaires.**

   These are completed in Paper form then scanned digitally to our Systems as a permanent record.

2. **If any of these are completed in paper form, we would ask for a copy of the current version to be sent via email.**

We do not require information regarding staff completed forms e.g. WHO safety forms however, we would request that forms initially completed by a patient and co-signed by a staff member at the time of the examination are included.

Please see the attached documents.

Please note that it is East Sussex Healthcare NHS Trust's FOI policy to only release the names of staff that are grade 8a or above. Therefore, any staff stated in the attached documents that are below that grade have been redacted.

If I can be of any further assistance, please do not hesitate to contact me.

Cont…/

Should you be dissatisfied with the Trust's response to your request, you have the right to request an internal review. Please write to the Freedom of Information Department (esh-tr.foi@nhs.net), quoting the above reference, within 40 working days. The Trust is not obliged to accept an internal review after this date.

Should you still be dissatisfied with your FOI request, you have the right of complaint to the Information Commissioner at the following address:

The Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire SK9 5AF

Telephone: 0303 123 1113

Yours sincerely

Freedom of Information Department
esh-tr.foi@nhs.net

East Sussex Healthcare NHS Trust

CONSENT FOR MAMMOGRAPHY WITH IMPLANT(S)

Breast implants present a particular challenge for mammography. The following risks apply when implants are present:

1. The implant may obscure breast cancer, potentially making detection with mammography more difficult.
2. To minimise these risks, the mammogram will be performed in line with the standards set by the Royal College of Radiologists (RCR) for exams conducted on women with breast implants. Two (2) views of *each* breast will be taken, as outlined below:

    a) The first set of images will be taken using standard RCR-approved techniques, with the breast and implant gently compressed to a minimum recommended standard.
    b) Occasionally, additional views may be required to better visualise a specific area.
    c) This could involve pulling the breast tissue forward, away from the implant, to allow better visualisation of more breast tissue but this will only be on recommendation from the breast Radiologist.

3. Even when correct procedures are followed, there is a very low but recognised risk of implant damage or movement during a mammogram. If the implant shifts or ruptures, surgery may be necessary. The Mammographer at East Sussex Healthcare is not liable for any damage to implants that may occur during the mammogram.
4. In cases of suspected implant rupture, Ultrasound or magnetic resonance imaging (MRI) are the preferred initial imaging options. If a mammogram is also deemed necessary after other preliminary investigations, this should be discussed with the patient by the referring physician, typically during a visit to the breast clinic.

I understand the risks associated with having a mammogram with breast implants and agree to proceed with the procedure. This consent form provides information about the risks involved in mammography with breast implants.

By signing this consent form, I confirm that:

1. I have read and understood the information provided.
2. I authorise and consent to the performance of the procedure.
3. I have been informed of the risks and have had the opportunity to ask any questions.

Patient/Relative/Guardian Witness (print):

Signature: _____ **Date:** _____

East Sussex Healthcare NHS
NHS Trust

DEPARTMENT OF RADIOLOGY

CT CARDIAC ANGIOGRAPHY PATIENT QUESTIONNAIRE

Surname: …… Forename(s)…….....

Address: ……

Date of Birth: ……. Weight: ……

Hospital Number……

Before we perform your CT scan, we must know the following information about your health:

Briefly explain why you are having this scan: …….....

1. Do you consent to having this examination done Yes / No
2. Have you had a previous CT scan? Yes / No
3. Do you have any allergies? Yes / No
   If yes, please give details: …….....
4. Do you suffer from diabetes? Yes / No
   If yes, do you take metformin tablets? Yes / No
5. Have you had an injection of IV contrast agent (x-ray dye) before? Yes / No
   If yes, did you experience any problems with that injection? Yes / No
   If, yes, please give details: …….....
6. Do you have a history of kidney disease? Yes / No
7. Do you have a history of cancer? Yes / No
8. Do you suffer from asthma? Yes / No
9. Are you on fluid restricted diet? Yes / No
10. Have you refrained from drinking caffeine and smoking prior to your scan? Yes / No
11. Have you had any Chest pain in the last 48 hours? Yes / No

The following questions apply to female patients only:

12. Are you, or is there any possibility that you may be, pregnant? Yes / No
13. Please give the start date of your last period: …….....
14. Please indicate if the following apply: Post menopausal, Sterilised, hysterectomy

By signing below, you acknowledge that you have answered the above questions as truthfully as you are able.

Signed: …… Date: ……

Radiographer's Signature: ……..

Patient Consent to share CT Scan with Hearthflow Inc (USA) for advanced analysis:

*'**I AUTHORISE*** sharing of my CT scan (which includes my Name, Date of Birth and CT images) for advanced cardiac CT analysis with our third party provider, Heartflow Inc.
Heartflow assures that all person identifiable information will remain within the EU whilst only de-identified image data will be analysed in the USA'

Patient Signature: ……Date: ……

I DO NOT AUTHORISE sharing of my data with third party providers, Heartflow inc.

Patient Signature: ……Date: ……

Before Scanning Radiographers MUST confirm and sign the following:-

I confirm that I :-

Attended the patient on CRIS ☐

Re checked full radiology history ☐

That **NO CT** has been carried out recently ☐

That this CT examination is necessary and should proceed. ☐

Any Comments……

Name of Radiographer……**Signature**……

Date……

Confirmation of the above by the Radiographer Performing the Scan before commencement of the scan.

Name of Radiographer……**Signature**……

Date……

Date and result of eGFR ……

CT Dose……

Images checked on PACS by……

Contrast used:

Saline used:

East Sussex Healthcare NHS
NHS Trust

CT Cardiac Angiogram Observations.

Name

Unit No:

D.O.B

Date:

Cons: NRP SSF ANS AJM RAV SP

Allergies: **Weight:** **Previous CABG: Y / N**

Current Medications: **Height:** **BMI:**

Time									
Rate									
Rhythm									
BP									
Sats%									

Contraindication to B-Blocker (e.g. Asthma): **Y / N**

Contraindication to GTN: **Y / N**

Oral Metoprolol given: **Time:**_____ **Amount:**_____

IV Metoprolol given: **Time:**_____ **Amount:**_____

Ivabradine given: **Time:**_____ **Amount:**_____

GTN given: **Time:**_____ **Amount:**_____

Comments:

Time Cannula removed: _____

Time discharged: _____

Prescribed by:

(Doctors signature)

Signed **Name**

Information for Carers and Comforters in Diagnostic Radiology

(Separate information is available for Nuclear Medicine and Radiotherapy exposures)

Under the Ionising Radiation (Medical Exposures) Regulations 2017, Carers and Comforters are defined as individuals knowingly and willingly incurring an exposure to ionising radiation by helping, (other than as part of their occupation), in the support and comfort of individuals undergoing a radiation exposure.

Any person supporting a patient or imaging plate must wear protective clothing, and stand as far from the main radiation beam as possible.

A light beam from the x-ray machine usually shows where the main radiation beam will be during the taking of the x-rays. You must not put any part of your body in this beam. This will ensure that you are exposed to scattered radiation only, which will be a very low dose. Please note that the light will usually turn off before the exposure happens but you should follow the instructions of the staff member directing you.

The Lead IRMER Practitioner has justified the very small additional exposure of carers and comforters to scattered radiation (ie not the main radiation beam) within general imaging where supporting an individual undergoing a radiation exposure is required to produce diagnostic quality images.

('Justified' means that it has been determined that the benefits significantly outweigh any potential risk from the scattered radiation.)

If the above rules, and any other instructions given to you by the radiographer, are followed, it is most unlikely that you would receive more than a trivial additional dose.
We would not expect anyone acting as a carers or comforter in x-ray to receive the equivalent of more than 24 hours of natural background radiation and often much less. Everyone is exposed to some radiation from the natural environment every day.

In some situations you may be provided with a personal dosimeter to wear under a lead apron. If so, please use it as instructed and ensure that it is handed back when you remove the apron at the end of the procedure.

If you have previously acted as a Carer and Comforter (holding patient or cassette during patient x-rays) please let us know as the small doses you receive each time will add up and a dose assessment may be required.

N.B. This document will be scanned and retained on the patient's record

Carer and Comforter Name ……

Relationship to Patient ……

Date of x-ray ……..……..

Previously acted as Carer and Comforter
(Y/N Including date(s) if known) ……....

Pregnancy status (If applicable) ..……..…

I have read and understood this document regarding the implications of acting as a Carer and Comforter:

East Sussex Healthcare NHS
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CT SCANNING DEPARTMENT– CT CARDIAC ANGIOGRAPHY QUESTIONNAIRE

Name:	Gender:
Date of Birth:	Hospital Number:

Your doctor has asked us to perform a CT scan of your heart and coronary arteries. We would like to know more about the reason for your scan and risk factors. Before and during the procedure it may also be necessary to administer a dose of a Beta- blocker to slow and steady your heart rate.

By answering the questions below you will provide information to help reduce any side effects.

What is the reason for your scan?	If you suffer from Chest or neck pain/discomfort:	
No symptoms, but for risk assessment	Does it occur on walking or exertion?	Yes/no
Chest pain or discomfort	Is it relieved with rest or GTN?	Yes/no
Shortness of breath		
Any other symptoms?		

Please answer the following questions:	Yes	No	Medications
Do you have High blood Pressure or on treatment?			
Do you have High Cholesterol or are on a treatment?			
Are you known diabetic?			
Do you currently smoke?			
Have you had heart attack before?			
Have either of your parents had a heart attack at an early age? (Father <55yrs; Mother<65 yrs)			
Have you had previous Angioplasty or Bypass graft? If yes, when and where?			
Have you taken any medication such as Viagra, Levitra, Cialis etc in the last 72 hours?			

FOR STAFF ONLY

Scanning details	
Protocol /technique used (calcium score/ angio, graft studies etc)	
Image acquisition cardiac phase (70-80%, 30-80% etc)	
Acquisition hearth rate (bpm)	
Betaloc	
Contrast bolus	
Kvp	
Dose	

Any ectopics/arrhythmia during scan: yes/no **if yes, did you edit ecg? Yes/no**

Any adverse reaction: **Additional drugs given:**

Any other problems during the scan?

East Sussex Healthcare NHS Trust

Radiology – Nuclear Medicine

CT Contrast Questionnaire

Patient Name ……

Hospital Number or Date of Birth ……

1. Do you consent to having this examination done? YES / NO
2. Have you had a previous CT scan? YES / NO
3. Have you had an injection of IV contrast agent (x-ray dye) before? YES / NO

   If yes, did you experience any problems with that injection? YES / NO

   If yes, give details……
4. Do you have any allergies YES / NO

   If yes, please give details ……
5. Do you suffer from diabetes? YES / NO
6. If yes, do you take Metformin tablets (Glucophage)? YES / NO
7. Do you have a history of kidney disease? YES / NO
8. Do you suffer from uncontrolled asthma? YES / NO

When injecting contrast there is a small risk that the vein could burst, and contrast could leak into the surrounding tissues. We have procedures in place to deal with this eventuality, and you will be advised at the time of scanning to let us know immediately if you feel any pain at the injection site or surrounding area during the procedure.

You acknowledge that you understand the information above and have answered all questions as truthfully as you are able.

Signed by Patient…… Date……

Radiographer/Technologist Signature…….. Date……

Office Use Only: Date and Result of eGFR _____

Renal Function (eGfr) within the last 3 months	Choice of contrast	Volume
eGfr >60	Omnipaque 300	100ml
eGfr 30-60	Visipaque 270	100ml
eGfr <30	No Contrast	0ml

Metformin stopped 24hr before scan Y / N / NA Stopped 48hr after scan Y / N / NA

Contrast Y / N If N, Reason:

Contrast 100ml Omnipaque 300 100ml Visipaque 270

Batch Number _____ Comments:

Expire _____

CT inpatient/A&E Safety Check

Patient X Number/Name:

Allergies?

Diabetes? Y / N Type 1 / 2 Metformin? Y / N

Asthma? Y / N

History of kidney disease/renal failure? Y / N

Confirm risk of extravasation of contrast has been explained to patient: Y / N

Imaging history checked? Y / N

Previous CT scan?.....

Confirmed scan required (initial)……

DLP _____ eGFR_____

_____

CT inpatient/A&E Safety Check

Patient X Number/Name:

Allergies?

Diabetes? Y / N Type 1 / 2 Metformin? Y / N

Asthma? Y / N

History of kidney disease/renal failure? Y / N

Confirm risk of extravasation of contrast has been explained to patient: Y / N

Imaging history checked? Y / N

Previous CT scan?.....

Confirmed scan required (initial)……

DLP _____ eGFR_____

DEPARTMENT OF RADIOLOGY - CT PATIENT QUESTIONNAIRE

NHS
East Sussex Healthcare
NHS Trust

Surname…… Forename(s) …….....

Address……..……

Date of Birth ……..…… Weight ……..……..…

Hospital Number…….. Height ……

Before we perform your CT scan, we must know the following information about your health, to ensure we are safe to continue with your scan and administer contrast

Briefly explain why you are having this scan……

1. Do you consent to having this examination done? Yes / No
2. Have you had a previous CT scan? Yes / No
3. Do you have any metal implants or joint replacements? Yes / No
4. Do you have any allergies? Yes / No
   - If yes, please give details……
5. Do you suffer from diabetes? Yes / No
   - If yes, do you take metformin tablets? Yes / No
6. Have you had an injection of IV contrast agent (x-ray dye) before? Yes / No
   - If yes, did you experience any problems with that injection? Yes / No
   - If yes please give details ……..
7. Do you take any blood thinning medication? Yes / No
8. Do you have a history of kidney disease? Yes / No
9. Do you have a history of surgery to your lymph nodes? Yes / No
10. Do you suffer from asthma? Yes / No
11. Are you on fluid restricted diet? Yes / No
12. Are you, or is there any possibility that you may be pregnant? Yes / No
13. Please give the start date of your last period …….
    - Please indicate if the following apply: post-menopausal / sterilised / hysterectomy.

When injecting contrast through a cannula there is a small risk that the vein could burst, and contrast could leak into the surrounding tissues. We have procedures in place to deal with this eventuality, and you will be advised at the time of scanning to let us know immediately if you feel any pain at the injection site or surrounding area during the procedure.

By signing below, you acknowledge that you have answered the above questions as truthfully as you are able and understood the information provided regarding risks. By signing you are consenting to proceed with the scan and administration of contrast when applicable.

Signed …… Date ……

Radiographer's Signature ……

Before Scanning Radiographers MUST confirm and sign the following:

- Rechecked full radiology history ☐
- Checked the date of last CT examination . . / . . / . . .
- Checked that **this** CT examination is necessary at this time and should proceed ☐

Any comments……..

Name of Radiographer……**Signature**……...

In addition to the above, the Radiographer scanning MUST also check and confirm that the clinical history and scanning protocol match:

Clinical history on request ☐

Scanning protocol ☐

Name of Radiographer…… **Signature**……..

Date…….

Cannula inserted by …… **Cannula Gauge** ……...

Cannula site …….. **Number of attempts** ……

When cannula is being inserted, please confirm that the information regarding extravasation has been explained and understood by the patient. ☐

Contrast injected at ……

Cannula removed by ……..... **Time** …….

Patient left department ☐

Date and result of eGFR……..

CT Dose……..

Images checked on PACS by……..

Contrast used:
Saline used:
Other drugs administered:
WHO surgical safety checklist for radiological interventions done.
Completed by

Deprivation of liberty safeguards comments

Patient Consent for CT Colonography

Patient Name…….. DOB..... Patient ID.....

Have you taken the prep and followed the diet? Did it work? Yes / No

Safety for CTC	**YES**	**NO**	**Comments**
Do you have any bowel disease? Diverticulosis, inflammatory bowel disease, ischemic colitis?			
Have you had bowel surgery? Have you had your appendix removed?			
Have you had a recent Colonoscopy? +/- Biopsy/Polypectomy			
Current hernia			

Statement of health professional:

NAME _____

SIGNATURE _____

ROLE _____

I have explained the risks of CT Colonography including symptoms of bloating and abdominal discomfort.	
I have explained that this test involves exposure to ionising radiation.	
I have explained the small risk (1 in 3000) of perforation and the action that would be taken if this occurs.	
I have explained the benefits of CTC in investigating the large bowel for cancer and pre-cancerous polyps, whilst providing additional information about the surrounding abdominal organs.	
I have explained the possible reactions/risks to Buscopan if using.	

Statement of patient:

I agree to undergo CT Colonography by a suitably experienced member of the team and understand the risks and benefits of the examination. **YES / NO**

I agree for my CT scan to be anonymised and used for teaching/training/research and audit purposes **YES / NO**

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

Radiographers/ RDAs involved in scan: Print Name

Rad/RDA 1 (Tube): …… Rad/RDA 2 (Chaperone): …… Rad 3 ……..

Diagnostic and Interventional Inclusive Pregnancy Status form (IPS)
12-60 years old

Your doctor/healthcare professional has requested an X-ray or other similar investigation that requires an exposure to radiation. As Radiographers, it is our professional duty and legal responsibility to ensure that we protect individuals from unnecessary exposures to radiation. This is particularly relevant when considering any potential risk to pregnancy where there is greater risk from the harmful effects of radiation.

1. Preferred name if you have one	
2. Which sex were you registered as at birth?	***Female*** ☐ ***Male*** ☐

If you are aware that you were born with a physical variation in your sex characteristics (VSC), also known by the terms diverse sex development (DSD) or intersex, please let the radiographer know. This can be discussed privately if you wish

IF YOU HAVE ANSWERED MALE TO Question 2, PROCEED TO No. 6 *PATIENT SIGNATURE & DATE*

Only answer the following if you have answered Female above, and/or have a VSC with the potential of pregnancy

3. Is there any possibility that you could be pregnant?	***Yes*** ☐ ***No*** ☐
4. Do you have menstrual periods?	***Yes*** ☐ ***No*** ☐
5. If yes, when was the 1st day of your last menstrual period?	

Patient Signature section

6. Patient Signature	
7. Date of birth	

For Radiographers only

8. Hospital number	
9. Staff name & signature	
10. Date today	

Making enquiries about pregnancy is a legal requirement. With your permission, a copy of this document will be stored electronically in your radiology notes. All your personal data is managed in line with data protection regulations.

Please inform a Radiographer if you do not consent, or consent to only part of this information being stored. Please note, we might not be able to continue, or it could delay your examination if we are unable to confirm your pregnancy status.

For Medical Doctors only

Clinical need overrides LMP status	☐
Medical Doctor name & signature	
Pregnancy test lot number if used	
Pregnancy test result	***Positive*** ☐ ***Negative*** ☐

I-131 Therapy Administration Worksheet

Adults Only procedure

THERAPY DATE _____

Capsule Measurement			
Calibrator QC OK?		Time	:
		Measured by	
Measured Act MBq		Checked by	
Prescribed Act MBq		Measured Act within 10% of Prescribed	

Name: _____

DOB: _____

X or NHS Number: _____

Stick Radioiodine pot label here or complete details

LOT NUMBER _____

Expiry Date _____

Has the request form been signed by the consultant with the correct activity specified?	Y/N
Are the patient name, address and date of birth correct?	Y/N
Does the patient understand they will be receiving a radioactive dose?	Y/N
Have pregnancy/breastfeeding checks (see reverse) been completed?	Y/N/NA
Has the patient been advised to avoid starting a pregnancy (F: 6 months, M: 4 months)?	Y/N/NA
Has the patient stopped relevant medication	Y/N
Has patient been informed of possible side effects? (Nausea/Palpitations/Ophthalmology/Dry mouth/Neck swelling/Thyroid Storm)	Y/N
Low iodine diet (see SOP) for 7 days before administration and for 2 days after administration?	Y/N
Has patient had liquids only for 2 hours before administration?	Y/N
Have the restrictions been explained to patient and do they understand them?	Y/N
Has a restriction card been given to the patient?	Y/N
Has the patient been advised to drink plenty of fluids for next 3 days?	Y/N
Has the patient been advised regarding crockery, food hygiene, flushing toilet twice, men sitting down to urinate and any other contamination possibilities for 3 days?	Y/N
Has the patient been told they must contact the NM Department if they vomit within 4 hours?	Y/N
Is the patient aware of blood test in 6-weeks' time and a follow-up consultation (endocrine)	Y/N
Has the procedure for taking capsule been explained to the patient?	Y/N
Has the patient signed a consent form for I-131 in OPD?	Y/N
Have the patient details been entered onto CRIS & Daybook?	Y/N

ADMINISTERED BY: _____ DATE/TIME: / / : _____

Pregnancy and Breastfeeding Form I-131 Therapy

For ALL Females aged 18 – 60 (Adults Only)

To be completed by person administering I-131

Patient Name: _____

D.O.B:_____ **Hospital Number X:**_____

Procedure: I-131 Therapy

Is her period overdue? No Yes Irregular

LMP _____(If greater than 10 days pregnancy test indicated)

Sterilized Hysterectomy Post Menopause

Contraception _____

Pregnancy Test No Yes Result _____ Date_____

Is Patient Pregnant? No Yes Unsure

Breastfeeding No Yes

Cancel if patient Pregnancy not excluded/ Breastfeeding or not followed patient prep

Is Radioiodine capsule OK to give? YES / NO

If NO state reason _____

Patient's sign: _____ Date: _____

Operator sign: _____ Date: _____

I-131 Therapy Pre Assessment Worksheet

Name: _____

DOB: _____

X or NHS Number: _____

1st Treatment	500MBq
Repeat Treatment	800MBq

(*Delete one*)

Has a request form been signed by the consultant with the correct activity specified?	Y/N
Has the patient signed a consent form for I-131 in OPD?	Y/N
Are the patient's name, address and date of birth correct?	Y/N
Has the patient received a patient information booklet?	Y/N
Does the patient understand they will be receiving a radioactive dose?	Y/N
Have pregnancy/breastfeeding checks (see reverse) been completed?	Y/N/NA
Has the patient been advised to avoid starting a pregnancy (F: 6 months, M: 4 months)?	Y/N/NA

Current Medication

Medication to Stop

Last Iodine Contrast date _____

Low iodine diet patient information sheet discussed/issued?	Y/N
Hospital Transport? (If Y Nuc Med staff must liaise with transport provider)	Y/N
Residential care?	Y/N
Public Transport Restrictions discussed?	Y/N
Sleeping Restrictions discussed?	Y/N
Employment restrictions discussed?	Y/N
Entertainment Restrictions discussed?	Y/N
Childcare restrictions explained?	Y/N
Has the patient been advised regarding crockery, food hygiene, flushing toilet twice, men sitting down to urinate and any other contamination possibilities (3 days)?	Y/N
Is the patient aware of blood test in 6-weeks' time and a follow-up consultation (endocrine)	Y/N
Has the procedure been explained to the patient?	Y/N

Planned treatment date:_____

Assessed By: _____

Pregnancy and Breastfeeding Form I-131 Therapy

For ALL Females aged 18 – 60 (Adults Only)

Patient Name: _____

D.O.B:_____ **Hospital Number X:**_____

Procedure: I-131 Therapy

Is her period overdue? No Yes Irregular

LMP _____

Sterilized Hysterectomy Post Menopause

Contraception _____

Is Patient Pregnant? No Yes Unsure

Breastfeeding? No Yes

Has patient received urine sample bottle for pregnancy test? No Yes

Cancel if patient Pregnant

Patient's sign: _____ Date: _____

Operator sign: _____ Date: _____

Scan completed assessment on to CRIS

Diagnostic and Interventional Inclusive Pregnancy Status form (IPS)
12-60 years old

Your doctor/healthcare professional has requested an X-ray or other similar investigation that requires an exposure to radiation. As Radiographers, it is our professional duty and legal responsibility to ensure that we protect individuals from unnecessary exposures to radiation. This is particularly relevant when considering any potential risk to pregnancy where there is greater risk from the harmful effects of radiation.

1. Preferred name if you have one	

2. Which sex were you registered as at birth? ***Female*** ☐ ***Male*** ☐

If you are aware that you were born with a physical variation in your sex characteristics (VSC), also known by the terms diverse sex development (DSD) or intersex, please let the radiographer know. This can be discussed privately if you wish

IF YOU HAVE ANSWERED MALE TO Question 2, PROCEED TO No. 6 *PATIENT SIGNATURE & DATE*

Only answer the following if you have answered Female above, and/or have a VSC with the potential of pregnancy

3. Is there any possibility that you could be pregnant? ***Yes*** ☐ ***No*** ☐

4. Do you have menstrual periods? ***Yes*** ☐ ***No*** ☐

5. If yes, when was the 1st day of your last menstrual period?	

Patient Signature section

6. Patient Signature	
7. Date of birth	

For Radiographers only

8. Hospital number	
9. Staff name & signature	
10. Date today	

Making enquiries about pregnancy is a legal requirement. With your permission, a copy of this document will be stored electronically in your radiology notes. All your personal data is managed in line with data protection regulations.

Please inform a Radiographer if you do not consent, or consent to only part of this information being stored. Please note, we might not be able to continue, or it could delay your examination if we are unable to confirm your pregnancy status.

For Medical Doctors only

Clinical need overrides LMP status	☐
Medical Doctor name & signature	
Pregnancy test lot number if used	

Pregnancy test result ***Positive*** ☐ ***Negative*** ☐

SECTION 2 - PRE-PROCEDURE

TO BE COMPLETED BY THE NURSING STAFF PRIOR TO THE PROCEDURE

Consent	
Primary	**Date:** ____/____/_____ **Time:** ____:____

Primary consent, including CONSENT 4 for patients that lack capacity, MUST be completed by the requesting team prior to the procedure.

Patient Preparation	
Last food intake - ____:____ hrs Last fluid intake - ____:____ hrs	Language barrier Yes ☐ No ☐ *If yes, Interpreter must be booked or translator to accompany patient*
Identity Band in place ☐ Red Alert Band in place YES ☐ N/A ☐ Reason for Red Alert Band _____	Contact lens removed YES ☐ N/A ☐
State any implants, prostheses or metal work:	Dentures (remove if ill fitting) YES ☐ N/A ☐
VTE prophylaxis: YES ☐ N/A ☐ Anticoagulation plan followed: YES ☐ N/A ☐	Gown: YES ☐ N/A ☐ Underwear: Disposable YES ☐ N/A ☐

Observations

INFECTION STATUS: Unknown ☐ Known ☐ (Please State)_____

BARRIER NURSING: MRSA ☐ E-Coli ☐ C-Diff ☐ Viral Hepatitis ☐ TB ☐ Other:_____
Check notes for HIV.

PREGNANCY STATUS: All females age 12-60 pls. Indicate last menstrual period ____/____/_____
If not, pregnancy test required. Positive ☐ Negative ☐

Baseline Observations (<4hrs prior to procedure)

Time	Weight (kg)	BP (mmHg)	HR (bpm)	Resp (pm)	O2 Sats	Temp	BM
:		/			% on Air /O2 ___		
:		/			% on Air /O2 ___		

Pre Investigations

Date	Hb	Platelets	INR	APTT	GFR	Urea	Creatinine	Potassium	Sodium

Comments:

Pre-Procedure Checklist			
ID bracelet	YES ☐ NO ☐ N/A ☐	Bowel prep given	YES ☐ NO ☐ N/A ☐
Allergies checked and documented	YES ☐ NO ☐ N/A ☐	Sedation required	YES ☐ NO ☐ N/A ☐
Pregnancy check (if applicable)	YES ☐ NO ☐ N/A ☐	Sedation explained	YES ☐ NO ☐ N/A ☐
Theatre gown	YES ☐ NO ☐ N/A ☐	Antibiotic prophylaxis given	YES ☐ NO ☐ N/A ☐
Dentures removed	YES ☐ NO ☐ N/A ☐	Blood results checked	YES ☐ NO ☐ N/A ☐
Hearing aid	YES ☐ NO ☐ N/A ☐	Anticoagulation stopped	YES ☐ NO ☐ N/A ☐
Glasses removed	YES ☐ NO ☐ N/A ☐	BM (if diabetic)	YES ☐ NO ☐ N/A ☐
Nail varnish removed	YES ☐ NO ☐ N/A ☐	Patients notes, Drug chart and observations	YES ☐ NO ☐ N/A ☐
Consent form	YES ☐ NO ☐ N/A ☐	Nil by Mouth from:	_____:_____
Procedure explained	YES ☐ NO ☐ N/A ☐		
Pre-med given	YES ☐ NO ☐ N/A ☐		

Documentation and Transfer
Medical notes ☐ Observation chart ☐ Prescription sheet ☐
Blood glucose chart/Sliding scale chart (if required) ☐
IV/CVC Site: _____ Date Inserted: _____
Any items or equipment required for transfer:

Pre-Procedure Sign Off and Handover to IRU Staff
Pre assessment completed by: Name _____ Signature _____ Date_____
Patient received by: _____ (IRU Nurse) Time and Date: _____

SECTION 3: RADIOLOGIST PRE OPERATIVE CHECK

Consent	
Secondary ☐	Date: ____/____/_____ Time: ____:____

Patient Co-Morbidities Directly Relevant to the Procedure	
Co-Morbidity	Notes
Completed by: _____	Signature: _____

East Sussex Healthcare
NHS Trust

RADIOLOGY DEPARTMENT, CONQUEST HOSPITAL

MAGNETIC RESONANCE IMAGING SAFETY QUESTIONNAIRE

MRI, unlike other methods of imaging the body, does not use radiation but uses magnetism and radio waves. Extensive evaluation has shown no long term adverse side effects related to MR imaging. However, the magnetic field can cause problems for patients with certain types of metallic implants. The following questionnaire is designed to identify any metallic items that you may have in your body which may exclude you from being able to have an MRI scan.

Surname …… Forenames……...

Address……X-Number……..

Date of Birth …….. Height…….…… Weight …….

The following questions need to be answered relating to any metallic objects that may be present in your body – please place a circle around your answer.

1. Have you had a previous MRI scan? Yes / No
2. Have you got a cardiac pacemaker or ever had any heart surgery? Yes / No
3. Have you EVER had any metal fragments in your eyes? Yes / No
4. Have you had any operations on your head or spine? Yes / No
5. Have you had any operations involving metal clips, pins or plates? Yes / No
6. Have you ever had any other type of implant in your body? Yes / No
7. Have you ever had any shrapnel injuries to your body? Yes / No
8. Have you ever had a fit or suffer from epilepsy? Yes / No
9. Have you any tattoos anywhere on your body? Yes / No
10. Do you have any diabetic monitoring attached? Yes / No
11. Have you had an endoscopy pillCam recently Yes / No
12. Has it been passed in your stool? Yes / No

Pregnancy statusy:

13. Are you, or is there any possibility that you may be pregnant? Yes / No
14. Are you breast feeding? Yes / No

If you have answered YES to any of these questions the Radiographer will need to discuss this with you before you are able to have an MRI scan.

By signing below you acknowledge that you have answered the above questions as truthfully as you are able.

Signed……. Date……...

Radiographer's Signature……

Patient Information

East Sussex Healthcare NHS Trust

Nuclear Medicine Bone Scan

Your doctor would like you to have a Nuclear Medicine scan and has arranged for you to visit our department. We would like your visit to be as pleasant as possible and hope this leaflet will answer some of the questions you may have. Should you have any questions regarding your appointment please contact us on one of the telephone numbers below between 9:00am and 5.00pm Monday- Friday.

0300 131 4797 or 0300 131 5537

WHAT IS A BONE SCAN?

A bone scan is a way of taking pictures of your bone metabolism. Images are taken using a Gamma Camera. A small amount of radioactivity is used to produce these pictures. The pictures will help your doctor understand your illness.

IS THE SCAN SAFE?

The amount of radiation you receive is as small as possible and is similar to other X-ray procedures. The radioactivity leaves the body very quickly and it will not make you feel sick or sleepy.

DO I NEED TO PREPARE FOR THE SCAN?

You do not need to do anything special. You can eat and drink normally and keep taking your tablets. You should wear loose fitting comfortable clothing. If possible avoid clothing that contains metal zips, buttons or fastenings.

IS THERE ANYTHING I SHOULD TELL THE STAFF BEFORE THE SCAN?

Females should tell us if they are pregnant, if they think they may be pregnant or if they are breast-feeding. Females between the ages of 12 and 60 will be asked to sign a form on the day of their test to confirm they are not pregnant. If there is any doubt then by law we have to perform a pregnancy test before we can do your test.

WHAT IS INVOLVED?

Shortly after you arrive you will be given an injection in a vein in your arm or hand. The injection is a radioactive tracer that is absorbed onto your bones. We do not expect you to have any side effects to the injection. **You will have a scan approximately 2-4 hours after the injection.** Your scan time will be confirmed after your injection. The scan will take up to 1 hour.

You will be asked to empty your bladder just before your scan and to remove any clothing containing metal and to empty your pockets. The scan involves taking pictures while you lie on a bed. The camera is placed close to the part of your body being studied. During your scan images are taken where the camera slowly moves from your head to your toes. Additional images include the camera rotating slowly around your body plus a CT scan is performed to help further assess your condition. It is important you keep very still during your scan.

PRECAUTIONS AFTER THE INJECTION

After your injection you should avoid prolonged close contact with pregnant females and children for 24 hours. Children and pregnant females should not accompany you to the department. You should also avoid blood tests and dental visits during this time. If you are planning to travel abroad within 7 days after your appointment please inform the staff during your appointment.

WHAT CAN I DO BETWEEN THE INJECTION AND THE SCAN?

You can leave the hospital or stay with us. Meals and snacks may be bought in the hospital If possible you should drink plenty of fluids and empty your bladder frequently.

WHAT CAN I DO AFTER THE SCAN IS COMPLETE?

You can go home or to work. You can drive a car and eat and drink normally.

WHAT HAPPENS TO THE RESULTS?

We cannot give you the results of your test. We will send a report to the doctor who asked for the scan as soon as possible.

Patient Information

CONSENT

Although you consent for this treatment, you may at any time after that withdraw such consent. Please discuss this with your medical team.

SOURCES OF INFORMATION

British Nuclear Medicine Society (BNMS)

IMPORTANT INFORMATION

The information in this leaflet is for guidance purposes only and is not provided to replace professional clinical advice from a qualified practitioner.

YOUR COMMENTS

We are always interested to hear your views about our leaflets. If you have any comments, please contact the Patient Experience Team – Tel: 0300 1314731 or email: esh-tr.patientexperience@nhs.net

HAND HYGIENE

The Trust is committed to maintaining a clean, safe environment. Hand hygiene is very important in controlling infection. Alcohol gel is widely available for staff use and at the entrance of each clinical area for visitors to clean their hands before and after entering.

OTHER FORMATS

If you require any of the Trust leaflets in alternative formats, such as large print or alternative languages, please contact the Equality and Human Rights Department.

Tel: 0300 1314434

After reading this information are there any questions you would like to ask? Please list below and ask a member of our team.

_____

_____

_____

_____

_____

_____

Reference

The following clinicians have been consulted and agreed this patient information:
Dr Emma Owens, Consultant Radiologist, ESHT
Dr David Sallomi, Consultant Radiologist, ESHT

The directorate group that have agreed this patient information leaflet:
Core Services

Next review date: April 2026
Responsible clinician/author: Mr Christopher Salt, Nuclear Medicine Modality Manager

East Sussex Healthcare NHS Trust

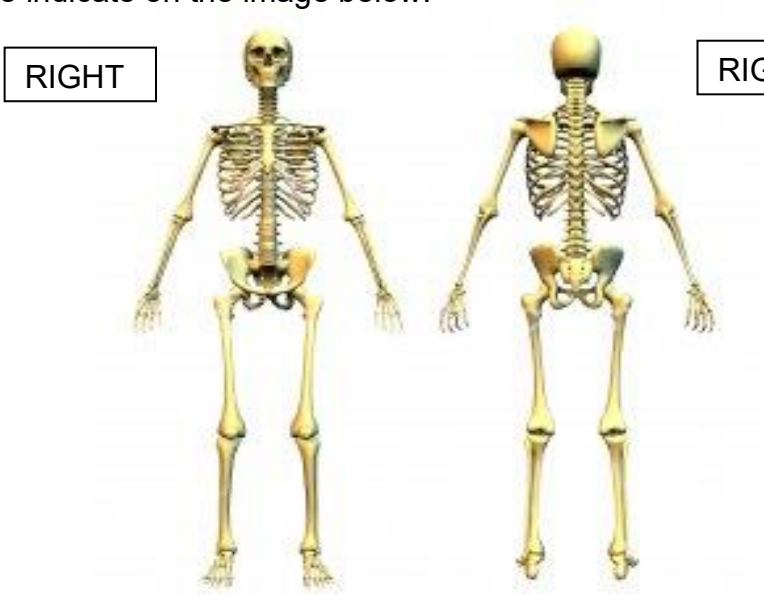
Patient Information

NUCLEAR MEDICINE BONE QUESTIONNAIRE

To help with the interpretation of your scan could you please answer some questions regarding your medical history?
Please bring this questionnaire with you when you attend for you scan.

HOSPITAL NUMBER: X	NAME:

1) Are you experiencing any specific aches and pains? **YES NO**
If **YES**, please indicate on the image below.



Have you had a fracture (broken a bone) in the past 2 years? **YES NO**
If **YES**, which one?

Have you had a fall recently that didn't necessarily require a doctor? **YES NO**
If **YES**, which part did you injure?

Have you had any previous bone or joint, surgery? **YES NO**
If **YES**, give details including date(s) of surgery

Have you had, or are currently receiving radiotherapy? **YES NO**
If **YES**, to which part of the body and when?

Have you had, or are currently receiving chemotherapy or hormone therapy? **YES NO**
If **YES**, when was your last treatment?

Are you on any treatment for osteoporosis? **YES NO**

Have you had any recent dental treatment? **YES NO**

Nuclear Medicine Procedure Worksheet

LABEL	Allergies Patient Weight	Patient Prep Medication Caffeine Colonoscopy +2/52 NBM Hydration	OK/NA

Dispensing		Dose calibrator isotope check			
Isotope/Radiopharmaceutical	RP Volume (ml)	Activity (MBq)	<10% of DRL	Time	Sign

Administration

PATIENT I.D. CHECKS			Clinical Details verified	Diabetic	Pregnancy/Breast Feeding & U.P. (sheet completed if required) PTO	Administration Site
Name	DOB	Address				

Radiopharmaceutical checked & administered by	Time	Other (or write "NONE") Contrast / Medicines (name / BN / exp.)	Administered by / Checked by	Time
			Admin: Checked:	

Imaging

Time	Patient ID Check (Name DOB Address)	CT Dose (DLP) mGy.cm	Sign
Comments			

Processing

Comments

Sent to PACS			Viewed on PACS	Form scanned	CRIS Completed
Raw Data					
Processed Data			Date	Time	Sign
3D Data/Datquant					

Pregnancy and Breastfeeding Form For Radiation Exposure (Females aged 12 – 60)

& Unlicensed Product Consent

To be completed by person who administers the Radiation Exposure

Date of Radioactive Administration: _____

Patient Name: _____

D.O.B:_____ **Hospital Number X:**_____

Procedure: _____**Radiopharmaceutical**_____

Is Patient Pregnant? No Yes Unsure LMP_____

Sterilized Hysterectomy Post Menopause

Contraception _____

Is her period overdue? No Yes Irregular

Pregnancy Test Indicated No Yes Result _____

Breastfeeding No Yes

Unlicensed Products (HIDA, PSMA, Tin Colloid and DPD only)–Patient has been informed that the Radiopharmaceutical used in this procedure does not hold a UK product license. Patient consents to this examination.

Patient's sig: _____

Operator sig: _____

Further dialogue with patient:

Decision if Pregnant/ Breastfeeding

Proceed ☐ Cancel ☐ Postpone ☐

Operator Sign: _____ Date:_____

Dose reduction advice from Doctor:_____

Advice given:

Pre CTC Checklist

Check the patients ID and appointment date.

	Yes	No	Action if yes
Iodine Allergy?			Radiographers cannot give Omni/Gastrograffin under the PGD if a patient is allergic to iodinated contrast **DO NOT GIVE THEM CONTRAST PREP** – discuss with a radiologist.
Diabetic?			Stop rapid acting tablets the day before and continue long acting and basal. Also advise patient to check bloods if they can and have sugary drinks/ sweets.
Iron Tablets?			Stop 7 days prior to CT as has leaves residue in bowel and can cause constipation.
Are you taking Laxatives?			Stop taking bulk forming laxatives 4 days prior (they have similar effect to fibre e.g. Fybogel, Isogel, Normacol) *Continue with osmotic laxatives as usual (under their Drs advice) e.g. lactulose (Duphalac and Lactugal), Laxido*
Stop any medicines that cause constipation			Stop 4 days prior to CT e.g. lomotil, loperamide (Imodium), or codeine phosphate
Egfr -			If below 30 needs discussing with radiologist.
Explained the diet and when to take Gastrografin. Explain may not have diarrhoea. Tell Patients ok to drink Gastrografin **Completed by:-**	**Name:-**		They can mix with squash to make it taste better and need to drink plenty of fluids (150mls/ hour). **Date:-**

Contrast Sticker:-

East Sussex Healthcare NHS Trust

Pregnancy Declaration Form
Risks from X-Rays and CT scans in Pregnancy

Q. Can I have an X-Ray or CT whilst pregnant?

You must let us know if you are pregnant, or think there is a chance you could be. This is because there is a small risk associated with exposure to medical X-Rays or CTs.

In some cases, your doctor may feel that the benefit to you and your unborn child from having an X-Ray or CT is much greater than the risk. It is important that your doctor is aware of any potential pregnancy in order to make that decision.

Q. What are the risks?

Exposure of your unborn child to radiation from medical X-Rays and CTs carries a very small increase in risk of childhood cancer. There is no risk of foetal death or birth defects at these levels.

We are all exposed to some level of radiation through the normal course of our lives. This can be from cosmic rays reaching the earth from space, from certain rocks (which may be contained in building materials), from travel (particularly flights), from some of the food we eat and from naturally occurring radon gas. In any one year, our exposure will vary according to where we have lived, where we may have flown to and what we may have eaten. During the course of a normal pregnancy, your unborn child will also be exposed to some of this radiation in the environment.

Q. How risky are X-Rays?

The list below gives some examples of typical X-Ray and CT examinations, the additional risk of childhood cancer per examination and a rough estimate how long it would take to receive the same amount of radiation from our environment.

Type of X-Ray examination	Additional Risk of childhood cancer per examination	Equivalent in environmental background radiation
X-Ray Arm X-Ray Chest CT Head	Less than 1 in 1’000’000	< few days
X-Ray Pelvis X-Ray Lower Spine CT Chest	1 in 100’000 to 1 in 10’000	A few weeks – a few months
CT Abdomen CT Lower Spine CT Pelvis	1 in 10’000 to 1 in 1000	Less than a few years

All X-Ray examinations are only performed if the risk of not having the medical information they will provide is greater than the risk from the radiation.

If you have any questions or concerns, please ask your Medical referrer or doctor.

An X-Ray or CT procedure of a pregnant patient is carried out when the patient's doctor has decided that the advantages of the exposure outweigh the potential risk.

By signing this form, you are confirming your understanding of the small potential risk as explained in the Risks of X-Rays and CT scans in Pregnancy factsheet overleaf.

I consent to this procedure and acknowledge that I have been given the opportunity to ask questions which have been answered to my satisfaction.

Patient's name: _____

Hospital number: _____

Patient's signature: _____

Interpreter's name (if used) : _____

Interpreter's signature (if used) :_____

Doctor responsible for consent (name & grade): _____

Contact number:

Doctor responsible for consent (signature): _____

Radiographers:

☐ The Patient has been given all of the information they required to make the informed decision to consent for this procedure.

☐ They have had the Opportunity to ask further questions if needed prior to acquisition.

☐ Exposure Factors/DAP:

Radiographer undertaking the examination (name): _____

Radiographer undertaking the examination (signature): _____

Date: _____