**EAST CHESHIRE PHARMACY CHEST XRAY REQUEST FORM**

**RADIOLOGY 01625 661370 RESPIRATORY SECRETARY 01625 661350**

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| --- | --- |
| **TITLE/SURNAME** | **BREATHLESS MORE THAN NORMAL YES/NO (Please circle)** |
| **FORENAME** | **COUGH/HAEMOPTYSIS YES/NO (Please circle)** |
| **DATE OF BIRTH**  **MALE/FEMALE** | **FATIGUE/LETHERGY YES/NO (Please circle)** |
| **ADDRESS** | **WEIGHT LOSS/POOR APPETITE YES/NO (Please circle)** |
| **POSTCODE** | **SMOKER (please tick)** |
| **NHS. NO.** | **EX SMOKER (please tick)** |
| **GP SURGERY** | **NON SMOKER (please tick)** |
|  | **ADDITIONAL INFORMATION** |
|  |  |
| **PHARMACY NAME/TEL NO.** | **DATE** |
| **PHARMACIST NAME/SIGNATURE** | **DATE XRAY COMPLETED (HOSPITAL )** |

**Dr.E.PARTRIDGE (Lead Radiology Consultant) PLEASE HOT REPORT AND SEND TO Dr.S.IYER (Respiratory Consultant) THANKYOU**

**Eligibility**

Patients registered with Cheshire East GP Practice

> 40 years old

Patients who have **1** or more of overleaf symptoms’ and are **current** or have **previously** smoked

Patients who have **2** or of overleaf symptoms’ and have **never** smoked

**Criteria - Exclusion**

Patient who have had a chest x-ray/CT in past 3 months

Patients who are already been investigated for respiratory symptoms

Patient who are not registered with Cheshire East GP Practice