Dorset County Hospital
NHS Foundation Trust

Diagnostic Imaging Department

Application for Non-Medical Referrer to Request Imaging

(Please note this form will NOT be processed unless fully completed and signed by all required parties)

Proposed Referrer		
Name (please print)	**Full Job Title**	**Professional Body/Reg No**
Work e-mail:		
Secondary e-mail to be used for urgent e-mails (MUST BE PROVIDED). Can be generic for report alerts but must be an NHS email:		
Work address:		
Rationale for applying for requesting privileges, including evidence of service requirement and how this will benefit patients:		
Protocol No Required (select from DCHFT Internet - NMR page)	**Are there existing NMR currently requesting in your Team with the same Role as you? If so which protocol, do they request under? Please explain if your protocols do not align.**	

Inclusion criteria (what examinations and for what reasons will you request imaging?)

List the specific imaging exams your delegating clinician supports you in requesting.

***Critical Information* This will form your defined scope of entitlement that you will be audited against**

Please copy/paste list if replicating an existing scope of entitlement

Modality	Body Part	Patient Age	Clinical Indication	Additional Information
Example **(please delete)** *X-Ray*	*Chest*	*>18 years*	• *NG insertion* • *Post Pacemaker insertion*	*Aspirate pH> 5.5 ? PTX*
CT	*Chest/Abo/Pelvis*	*>18 years*	• *Cancer staging scan*	

Exclusion criteria (please specify any restrictions e.g. age/examination type)

Has the proposed referrer attended or booked DCH IRMER Training to understand their legal obligations in respect of requesting ionising radiation examinations (IR(ME)R 2017)? DCHFT Intranet – NMR page. Please specify date below:
Are you currently, or have you previously been, a referrer at another Hospital? (please state which Hospitals)
What relevant professional qualifications do you have? (please provide evidence) • **You need to be qualified for 2 years to Apply to be an NMR for Diagnostic Imaging**

Professional qualification	**Place of Study**	**Year of Qualification**

Are you currently in a Training Post? Y/N **Guide Competence Framework Template to be submitted (DCHFT Intranet – NMR page)**
Please provide details and estimated year of completion:
How long have you worked in your current/specialist role? (Please provide previous role(s) if <1 year)
Under IRMER Regulations responsibility for imaging lies with the referrer however overarching clinical responsibility is accepted by the Delegating Clinician as named below:

It is the legal responsibility of the requesting Clinician/Team to <u>read and act</u> on report findings   **Who is going to act upon the imaging/report if this is not you as the referrer? In this scenario, a pathway must be in place with radiology approval. Please attach documentation e.g SOP(your Application will not progress without this evidence).**
What image interpretation qualifications/experience do you have? (please provide evidence where possible)

Please sign the form below and obtain the signature of both your Delegating Clinician and Departmental Manager/Service Lead before returning your application

As the Applicant I confirm that:

- **I have read and agree to the responsibilities as outlined in the NMR Responsibilities Document.**
- **I am aware that it is my responsibility to respond to and act on any urgent, significant or unexpected finding emails that I receive.**
- **I have had at least two years' experience post registration**
- **I have the advanced practice clinical assessment and decision making skills for assessing and managing patients that will enable me to work as a referrer**
- **I have read the Employers Procedures relating to IRMER**

Applicant Name	**<u>Digital</u> Signature**	**Date**

As the Delegating Clinician (Dr) I confirm that:

In relation to the requesting of Ionising Radiation procedures in accordance with this Application, **please tick** the boxes below:

☐ **There is a clinical need in the applicant's role for referring patients for imaging**

☐ **I confirm the above applicant has the appropriate clinical assessment and decision making skills to be able to apply the principles of referring to their own area of practice and is working to approved clinical guidelines.**

In addition, please tick **one** option from the statements below:

☐ **I confirm the above applicant is competent to understand and act on the imaging report for the procedures requested and hereby delegate responsibility for this action to the above named. In the event of any query on an X-ray image or report findings, the advice of a Senior Clinician will be sought**

OR

☐ **In exceptional circumstances another party retains overall responsibility for the patient and will remain responsible for acting on the report. In such a scenario a SOP/Pathway must be provided with this Application**

Delegating Clinician Name and Designation (please print)	**Digital Signature**	**Date**

As the Departmental/ Practice Manager/ Service Lead I confirm that:

- **There is a clinical need for the Applicant to request imaging and I therefore support this application**
- **I confirm that I am happy to receive and act on any urgent, significant or unexpected finding reports that this referrer does not initially respond to.**

Name and Designation (please print)	**Digital Signature**	**Date**

Please return this completed Application form to NMR@dchft.nhs.uk

NMR Team Use only	
Approved Entitlement to refer **YES/ NO**	**Signature Chair Medical Exposures Group / Consultant Radiologist/ IR(ME)R Practitioner for the Trust**