ICE Access Request Form - GP Practices

**Once complete, please return to: The LDH IT Service Desk –** **itservicedesk@ldh.nhs.uk**

|  |  |
| --- | --- |
| Name of Practice: |  |
| Practices National Code: |  |
| Practice Manager: |  |
| **Do You access ICE in another area/Hospital?****If so, please provide Code Number** |  |
| Direct contact number for Practice Manager: |  |
| Email address for Practice Manager: |  |
| Email for account information to be sent to:(This email will receive all new user account set up confirmations) |  |

(Please make sure the above information is correct at time of request)

**Please complete the appropriate section below, making sure that all relevant information is supplied. Any missing information could lead to a delay in the account being created**

**General Practitioners**

|  |  |
| --- | --- |
| First name: |  |
| Surname: |  |
| Professional Registration number (GMC): |  |
| Practice lead: (if yes, please provide GMP number below) | Yes / No |
| GMP: |  |
| Job role: |  |
| Will the GP/Locum need to request tests in their own name? | Yes / No |
| Locum?: (if yes, please specify for how long) |  |

**Allied Health professionals (Nurse, Midwife, Advanced Practitioners, Pharmacist)**

|  |  |
| --- | --- |
| First name: |  |
| Surname: |  |
| Professional Registration number: |  |
| Job role: |  |
| Does the user work at other practices? | Yes / No |

**Administrative services**

|  |  |
| --- | --- |
| First name: |  |
| Surname: |  |
| Job role: |  |
| Does the user work at other practices? | Yes / No |

***Please notify the Trust when staff leave the practice so our system is up to date.***

**Authorisation for Non-Medical Staff to Request X-Ray/CT Examinations – Version 4 Mar 2019**

This document will authorise you to act as a Referrer under IRMER 2017 within defined parameters.

1. Name and job role:
2. Professional qualification, regulating professional body, registration number:
3. Patient group you will be making referrals for:
4. IRMER training carried including dates (attach copies of certification):
5. Will you be referring as part of a clinical team where either the team will act on a radiology report or where a doctor will do an initial review of the imaging prior to radiology issuing a report **OR** referring as an autonomous practitioner who will be reviewing the images and making a decision on patient treatment prior to the radiology report being issued.

**Please specify:**

**a) The protocol under which you can refer will be agreed based on your speciality/job role - you will be notified of this once your request to refer has been authorised.**

**b) X-ray and scanning requests must conform to the Guidelines issued by the Royal College of Radiologists (please see I-Refer on the intranet).**

**c) A consultant/GP must be willing to take responsibility for your referrals.**

I agree that I will ensure a full and complete clinical history is provided in all referrals, including relevant past medical history and the results of investigations. I will always include the findings on clinical examination and make it clear in each request the clinical question to be answered.

**Staff Member:**

Signed: Name:

E-mail address:

**Supervising Consultant/GP:**

Signed: Name and Qualifications:

Date: Surgery Name:

**Authorisation from the Chair of the MEC**

Signed: Name: Date: