Audit for Radiological Examinations requested by named Nurses, Paramedics, Clinical Pharmacists, Physiotherapists and Podiatrists employed by General Practice or PCNs within Devon and Cornwall.

**Please refer to the “Protocol for requesting Radiological Examinations by named Nurses, Paramedics, Clinical Pharmacists, Physiotherapists and Podiatrists employed by General Practice (GP) or Primary Care Networks (PCN) within Devon & Cornwall.”**

To ensure all named members of the Multi-disciplinary workforce comply with the above protocol and to provide evidence towards the four pillars of Multi-Professional Advanced Practice, please complete this audit on a 3-yearly basis with your clinical supervisor.

Once completed, please inform the Radiology department to which you submit referrals to so they can update their records. As part of the ongoing governance regarding requests you may be required to provide this evidence at ad hoc times over the course of your employment.

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| **Date:** |  | | | | | |
| **Practitioner name:** |  | | | | | |
| **Job role:** |  | | | | | |
| **IR(ME)R number:** |  | | | | | |
| **Educational Supervisor name:** |  | | | | | |
| **Educational Supervisor role:** |  | | | | | |
| **Practice name:** |  | | | | | |
| **IR(ME)R update completed:** |  | | | | | |
| **\*Number of Imaging requests for each audit year:** | **Year 1** |  | **Year 2** |  | **Year 3** |  |

\*If this data is not readily accessible, then an estimate may be appropriate, or radiology can be contacted for further support.

*To ensure the protocol is fit for purpose please answer the following question:*

What changes would you make to the protocol that would improve the service to patients and be within your scope of practice?

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| **Patient number** | **Complete patient details?**  1 – Name  2 – DOB  3 – Address  4 – NHS/Hospital No  **(yes/no/partial)** | **Complete Referrer details?**  1 – Name  2 – Job Title  3 – Contact Number  4 – Registration No  5 – Signature (if applicable)  **(yes/no/partial)** | **Examination & Modality (e.g. PF, CT, MRI etc.) requested** | **Was this an appropriate investigation as per iRefer guidelines/agreed pathways?**  **(yes/no/unsure)** | **Did it have appropriate clinical details i.e. did it meet the protocol requirements**  **(yes/no)** | **Has there been any duplication of imaging requests?**  **(yes/no)** | **How has this request impacted on patient management?** |
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