Audit for Radiological Examinations requested by named Non Medical Referrers employed by General Practice or PCNs within the BNSSG area.

**Please refer to the following:** Protocol for requesting Radiological Examinations by named Registered Professions employed by General Practice (GP) or Primary Care Networks (PCN) within the Bristol, North Somerset and South Gloucestershire (BNSSG) area V2.6

* An audit of NMR imaging and a review of the protocol must be performed at least every three years by the Practice Management or nominated lead for Non Medical referrers.
* A Minimum of 30 requests across the cohort of staff in the Practice and scope of requesting ensuring equal representation of all NMR roles
* Audit results and the reviewed protocol will be submitted to [RadiologyNonMedReferrers@uhbw.nhs.uk](mailto:RadiologyNonMedReferrers@uhbw.nhs.uk) OR [nmr@nbt.nhs.uk](mailto:nmr@nbt.nhs.uk) for re-ratification by the IR(ME)R sub-committee.
* The responsibility for ensuring the audit and the review are performed remains with the author.
* As part of the ongoing governance regarding requests individuals are required to undertake an audit of their own practice as part of their annual review of clinical practice or appraisal.

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| **Date of Audit:** |  |
| **Author Name:** |  |
| **Author Email:** |  |
| **Employed Role:** |  |
| **Practice Name:** |  |
| **Are all your staff up to date with their IR{ME} R Training?** |  |
| **Have you checked all NMRs who have left employment or had a change in circumstance have been removed or amended on ICE?** |  |
| **What changes would you make to the protocol that would improve the service to patients** |  |

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| **Patient number** | **Complete patient details?**  **(yes/no)** | **Complete referrer details?**  **(yes/no)** | **Examination requested** | **Was this an appropriate image?**  **(yes/no)** | **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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| **Patient number** | **Complete patient details?**  **(yes/no)** | **Complete referrer details?**  **(yes/no)** | **Examination requested** | **Was this an appropriate image?**  **(yes/no)** | **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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| **Patient number** | **Complete patient details?**  **(yes/no)** | **Complete referrer details?**  **(yes/no)** | **Examination requested** | **Was this an appropriate image?**  **(yes/no)** | **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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