NHS
Wood Green
Community Diagnostic Centre

Clinical Model for the Wood Green NHS Community Diagnostic Centre

Contents

Background

Wood Green Community Diagnostic Centre (CDC) is being developed in response to a recommendation from the Sir Mike Richard's report Diagnostics Recovery and Renewal. The goal of these community facilities are as follows:

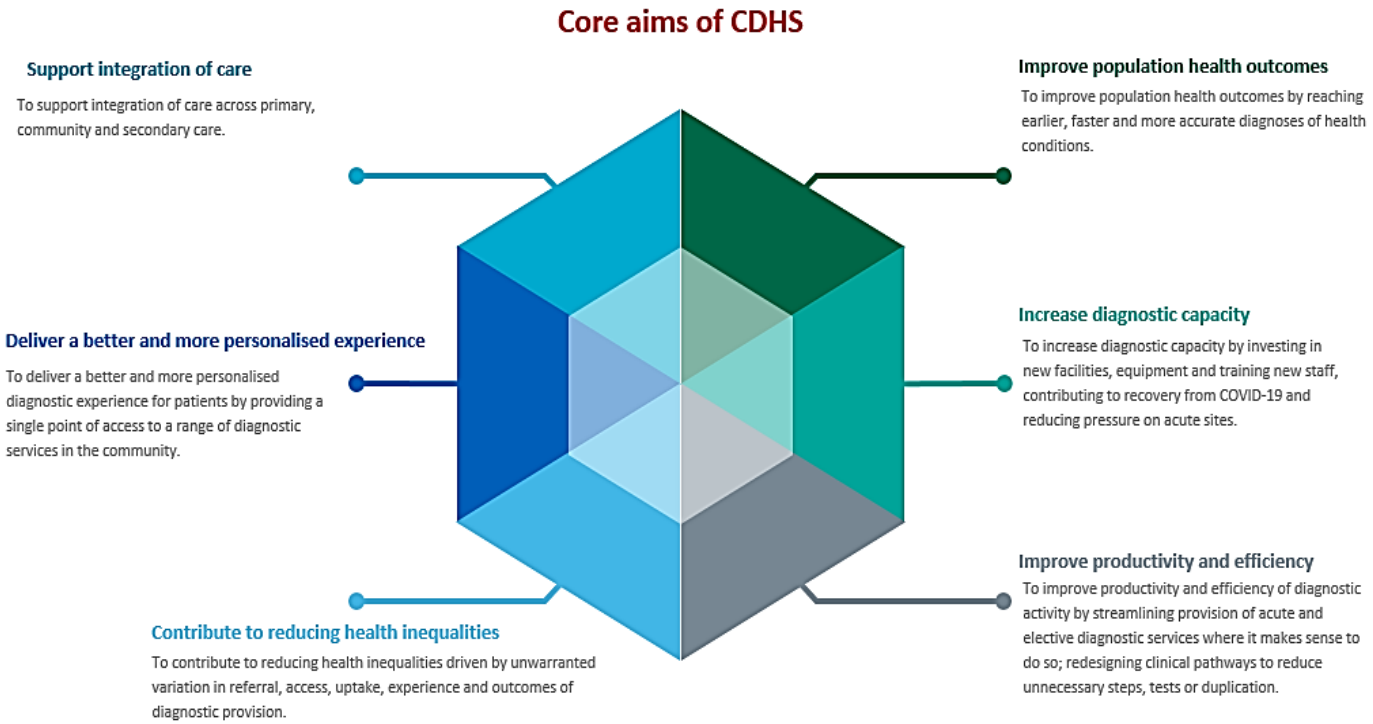


Figure 1

Objective

This document seeks to define the Clinical Model for the services in the CDC. It will define:

- Scope of the service including patient cohort
- The referral pathways into the CDC
- The reporting pathway for results to the referring clinicians including escalation of unexpected or urgent findings

The clinical model is required to drive the operating model of the CDC

- the specific skill sets of sonographers
- consultant job descriptions
- evacuation plans and fire strategy
- administrative functions.

It will also be used to drive the communication strategy in terms of what a service user can expect of the service.

The plan is to create a clinical model for phase 1 priority. The services for Phase 1 are: shown in the table below

Executive Summary

Workforce

- The initial objective of the CDC was to deliver the following services in Phase 1:

I. X-ray: Mon to Fri 8a-8p, Sat and Sun 9a-5p
II. US: Mon - Fri 8a-8p
III. Phlebotomy: Mon to Fri 8a-8p, Sat and Sun 9a-5p
IV. Ophthalmology: Mon to Sat 9a-5p

- Due to recruitment challenges this document describes the amended clinical model required to opening of the CDC. The aim will be to deliver the clinical objective as the centre becomes established and the workforce developed.

X-Ray

- The original model was based on hiring reporting radiographers who would do both acquisition and reporting of x-rays. This model would allow for contemporaneous reporting.
- Recruitment challenges have resulted in a change to the clinical model such that we will create developmental linked grade roles where the radiographers will do 80% acquisition and 20% reporting training via a formal training programme. Once they have qualified and have been signed off as competent to report independently, they will be uplifted to band 7.
- If we fail to attract radiographers wishing to take-up a developmental role, then we will need to employ agency radiographers for acquisition only until such a time that we can achieve either of the above staffing models. The cost implications may mean reduced hours of the centre in order to ensure meet the financial constraints in the initial stages.
- To ensure that the CDC fulfils its ambition to ensure a quick turnaround time on all x-rays, we are considering two reporting models:
  I. Outsourcing: We will utilise the outsourcing infrastructure and SOPs in place at the Whittington Health to outsource all x-rays performed at the CDC to an external outsourcing company.
  II. Insourcing: We can develop an insourcing model that either follows the NCL insourcing model that is currently being developed or develop a Whittington Lead insourcing model with Whittington staff reporting on all x-rays within the specified timeframes.
- Until we achieve the reporting radiographer model which will allow for the original ambition of a 24-hour turnaround time we will now aim for 1 working day as our turnaround time

Ultrasound

- The original model was based on hiring sonographers who would do both acquisition and reporting of ultrasound scans.
- Recruitment challenges have resulted in a change to the clinical model such that we will need to explore two options:

I. Recruit staff with little or no UK experience in ultrasound and develop them until they meet the required competency.
II. Create developmental linked grade roles where sonographers will be trained by a qualified agency sonographer (or equivalent) for the duration of their training

Phlebotomy

- The CDC is a 2-phased programme with the second phase involving the relocation of the phlebotomy service into the basement, alongside CT and MRI.
- Works for phase 2 will begin approximately 16 weeks after the opening of the CDC which means that the phlebotomy service would either:
  I. Need to be relocated to another site within the community
  II. Be temporarily suspend until phase 2 works have been completed

Imaging Services at Wood Green CDC

Author: Adrian Trinidade, Senior Operations Manager

Clinical Lead: Dr Jeevan Kumaradevan, Dr Maria Nordlander, and Dr Jane Young

Personnel involved/consulted: Cheryl Hill, Deputy Director, ACW, Whittington Health

Sign off: WH Radiology Board

WH CDC Steering Group

CDC CAG Feb 2022

Patient cohort

Service	Patient Group	Capability	Exclusions/Comments
Ultrasound	Age	Adults only	All under 18s will need to attend their local Trust for US scans
	Mobility	Ambulant or partially ambulant patients	The facility does not have an access ramp for bedbound patients or patients requiring transport via trolley/stretcher. Patients who can transfer in and out of a wheelchair independently or with minimal assistance can be accepted. Patients requiring NHS Transport services cannot be accepted.
	Referral types	Abdominal &	**Exclusions:** **Obstetrics:** Should not be performed on site as there is a high potential of finding anomalies on the scan that may require immediate intervention or support from the midwifery team. These scans are best performed in the hospital setting where urgent medical/psychological care can be provided. **Thyroids** - These can only be performed if there is a suitably qualified number of staff according to the latest and most current guidelines. **MSK** - US MSK referrals are best managed under specific pathways developed under the guidance of orthopaedics and physiotherapists.
		Gynaecological only	
	Acuity	Independent	Patients who require their vital signs to be continuously monitored cannot be accepted for health and safety reasons. No in-patients will be accepted. No clinically urgent scans that may require immediate medical intervention
	Referral Source	Any qualified referrer	All referrers wishing to utilise the CDC will need to be registered with the Whittington Health to allow transfer of results

Table 1

Service	Patient Group	Capability	Exclusions/Comments
X-Ray	Age	Adults only	All under 18s will need to attend their local Trust for x-rays
	Mobility	Ambulant or partially ambulant patients	The facility does not have an access ramp for bedbound patients or patients requiring transport via trolley/stretcher. Patients who can transfer in and out of a wheelchair independently or with minimal assistance can be accepted. Patients requiring NHS Transport services cannot be accepted.
	Referral types	All referrals that fall within RCR Guidelines	**Exclusion**: OPG/dental x-ray and as we do not have this machine available
	Acuity	Independent	No patients who require their vital signs to be continuously monitored. Monitoring devices are not provided on site
	Referral Source	Any qualified referrer	GP surgeries wishing to refer to the centre will need to complete a form which confirms medical and non-medical referrers and also surgery address to ensure they can be set up on systems.

Table 2

Referral Routes

The CDC can accept referrals from any registered NHS body within NCL. The method of referring into the CDC will be determined by the location of the referring service and the method of requesting the test. For the purpose of this paper, community referrals will refer to any registered service other than a GP or an NHS Trust. Figure 2 shows the pathway for referral to scan for both Trusts and GP/Community referrers. ICE refers to Sunquest ICE, the ordercomms system used by the CDC.

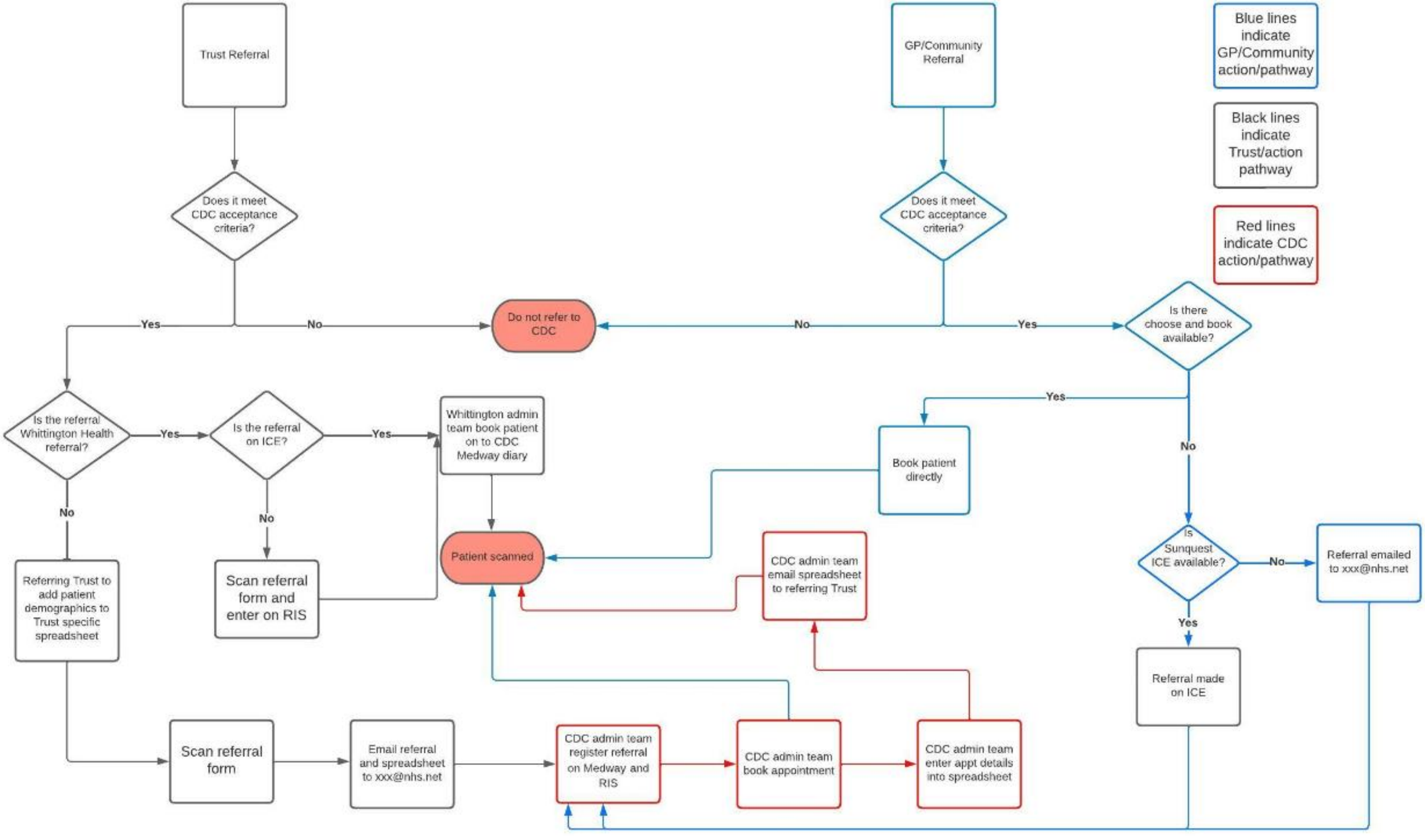


Figure 2: Imaging referral to the CDC

Directory of Service

The case mix is defined by the Directory of Service (DoS). The DoS is a central directory that is integrated with the NHS e-Referral Service (e-RS) and holds information about the services available at an organisation, allows referring clinicians to search for appropriate organisations to whom they can refer their patient's, and gives the clinician the ability to search which of these organisations are closest to the patient's home. Please see appendix 3 for a full list of examinations we accept at the CDC

Appointments

Appointments can be booked in several ways depending on the pathway, modality, and examination. Table 3 shows the different ways in which a patient can receive appointments

	Choose and Book (eRS)	E-mail	Walk-in	Direct Medway
X-Ray			✓	
Ultrasound	✓	✓		✓

Table 3: Appointment routes by modality

Email referral – The referrer emails referrals.woodgreencdc@nhs.net with a copy of the request form. The admin team will download and print the request and send to the appropriate modality for vetting, if appropriate. Once the vetting process has been completed, the admin team books the appointment and sends the appointment letter to the patient.

Enquiries

All clinical enquiries should be sent to enquiries.woodgreencdc@nhs.net. We aim to respond to enquiries within 2 working days.

Walk-in – The referrer provides the patient with a copy of the request form

Direct Medway – Trusts with access to Whittington Health's Medway/Careflow can book directly into the diaries assigned to them by the CDC. Figure 3 shows the flowchart for Direct Medway appointment management and is to be used in conjunction with the *Appointments Management* SOP. Should Trusts wish to book appointments directly into the CDC they will be given designated clinic codes which can only be access by themselves and the CDC.

Post Appointment Administration

Reporting

The CDC will provide a spectrum of modalities and the report turnaround times will vary depending on the service that is being offered. Table 5 shows the anticipated turnaround times for reports from time images were acquired to the time of the report, based on clinical priority

Clinical reporting will be undertaken by a mixture of reporting radiographers and consultant radiologists. The Whittington Health Consultant Radiologists will provide clinical support to the CDC as agreed at Radiology Board. See

Modality	Priority	Turnaround time	Responsible person
X-ray	All	3 working days	Radiologist/Advanced Clinical Practitioner
US	All	3 working days	Radiologist/Sonographer

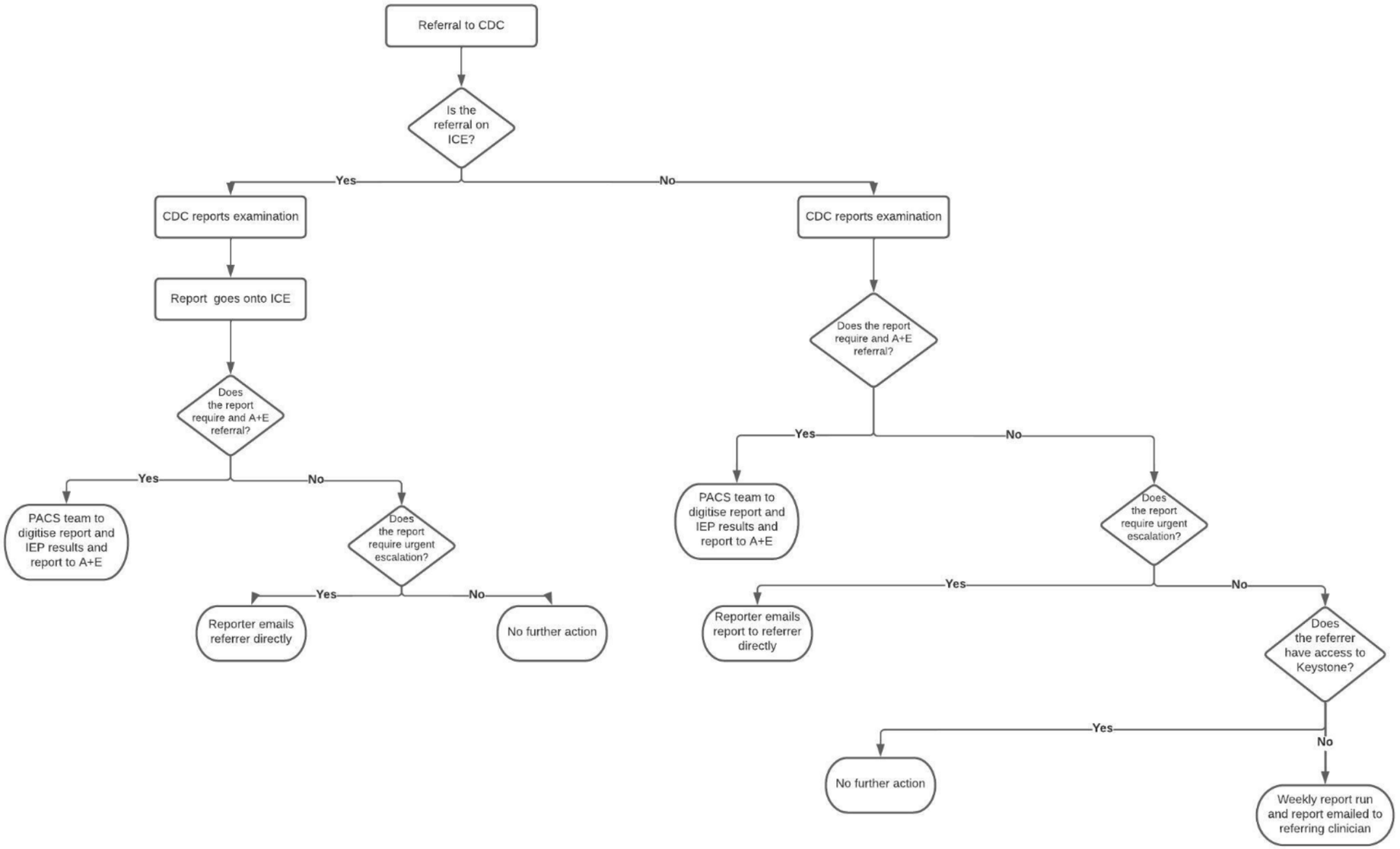
Table 5: Reporting turnaround times

Report Dissemination, Critical Alerts and Unexpected Findings

All clinical examinations must have a formal report attached to them and the results would be relayed back to the referring clinician based. Reports will be escalated depending on the urgency of the findings. Table 6 shows the list of conditions and the times in which the reports should be escalated. This list is not exhaustive and it the decision of the clinical team to escalate any findings as appropriate. Critical results refer to imaging exams that require immediate or urgent communication with the provider. These findings reflect conditions that are life threatening or conditions that require immediate change of management.

Unexpected Findings refer to imaging exams that the reporter reasonably believes may be seriously adverse to the patient's health and may not require immediate attention but, if not acted on, may worsen over time and possibly result in an adverse patient outcome.

The CDC proposes trialling the use of AI software to screen acquired x-rays which will produce an initial report that can then be prioritised which x-rays need to be reported on based on the initial report.



Please note that this is pathway for the CDC only and does not impact or supersede on the pathways that exist within secondary care

Figure 3: Results dissemination

Red: Escalation to A+E within 60 minutes of report finalization	Blue: Escalation to referrer within 24 hours	Green: Escalation to referrer within 72 hours
Chest 1. New (unexpected) pneumothorax without chest tube 2. Life threatening line/tube misplacement 3. Acute pulmonary embolism or acute aortic syndrome 4. Retained foreign body Abdomen 1. Unexpected pneumoperitoneum or significant haemorrhage 2. New florid pneumatosis or findings of ischemic bowel 3. Small bowel volvulus 4. Any finding that could require same day surgery (ex. acute cholecystitis or acute appendicitis) 5. Active GI bleed Ultrasound 1. Ectopic pregnancy 2. New occluded arterial bypass graft 3. AAA >5cm with free fluid 4. New aortic, carotid or mesenteric dissection -New mesenteric or transplant organ venous/arterial thrombus 5. Ovarian or testicular torsion Neuro 1. Unexpected new intracranial haemorrhage 2. New cord compression MSK 1. New fracture	Chest 1. Unexpected pneumonia or opportunistic infection 2. Significant pericardial or tension pleural effusion 3. Unexpected intracardiac clot 4. Suspected acute Tb 5. New whole lung collapse 6. New SVC syndrome Abdomen 1. New intra-abdominal abscess 2. Acute diverticulitis 3. Complicated or unexpected bowel obstruction 4. New biliary obstruction intussusception 5. New ureteral calculus Ultrasound 1. Pseudoaneurysm/AVF 2. Molar pregnancy 3. New deep vein thrombosis 4. New Endoleak 5. AAA >5cm Neuro 1. New subdural empyema 2. Metastatic lesion close to nerve root canal MSK 1. Subacute fracture 2. New bone infection	Chest/Abdomen 1. Unexpected thoracic aneurysm 5cm 2. Unexpected (suspected/possible) malignancy Ultrasound 1. Any recommendations for FNA/Bx MSK 1. Hardware malfunction

Table 6: Escalation Timescales based on critical or unexpected imaging findings

GP results: Results will be sent to GP surgeries via Keystone, a broker that links to PACS and allows reports to be automatically sent to the referring surgery. Surgeries that do not have access to Keystone can request access via the PACS team. Surgeries not wishing to have access to Keystone will have their

results disseminated to them via email, which must be provided to the CDC on the request form.

Trust results: Trusts with access to the Trust's ordercomms software, Sunquest ICE, can view results using this software. Referrers without access to Sunquest ICE, will receive their results and images via IEP. The report will need to be manually digitised (where required) and added to the images by the PACS team.

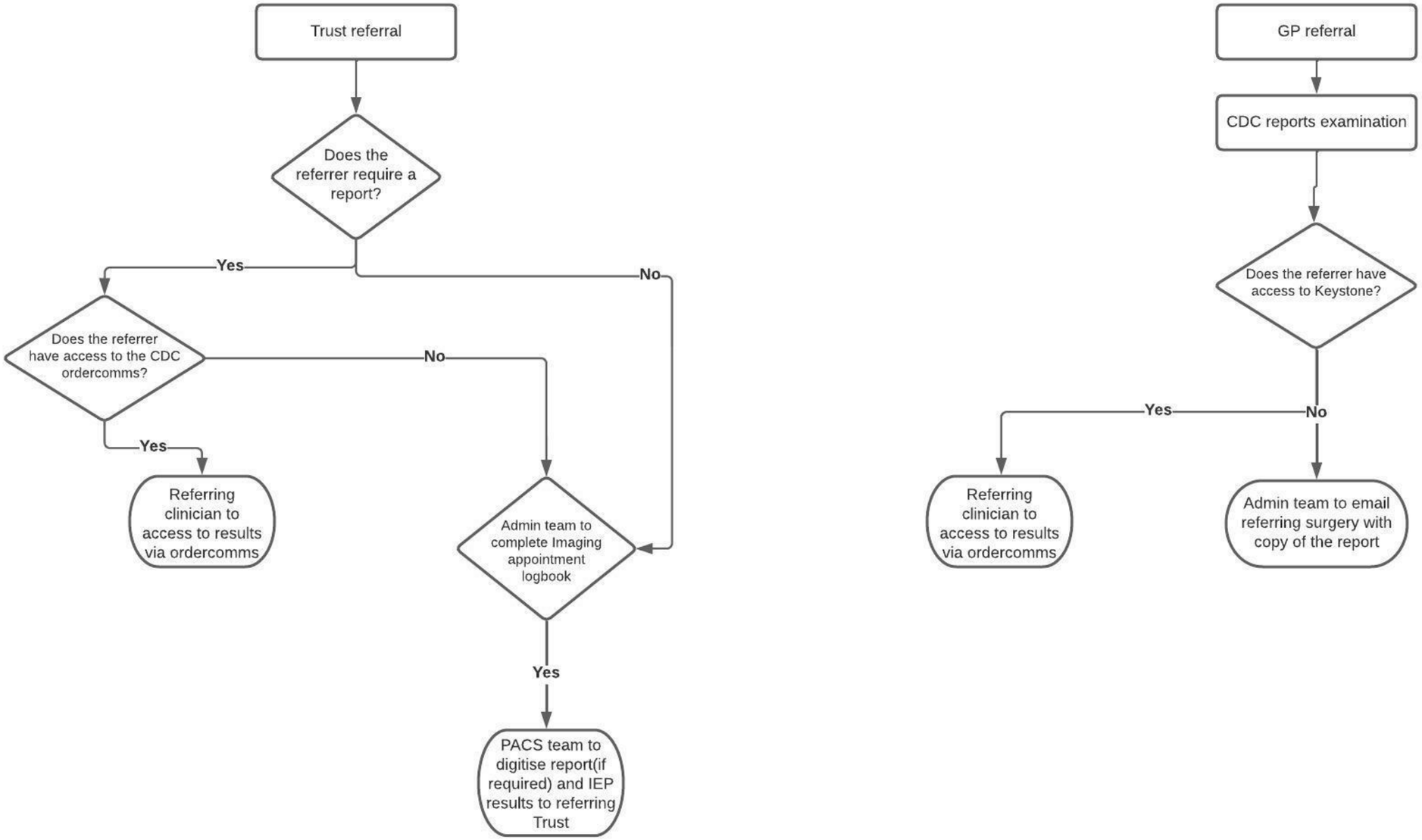


Figure 4: Results Dissemination

Phlebotomy Service Description

Author: Nazia Hussain - Operational Pathology Manager & Service Transition Lead

Clinical Lead: Helen Taylor

Personnel involved/consulted: Daniel Ayettey, Phlebotomy Manager

Sign off: Pathology Board

Patient cohort:

Service	Patient Group	Capability	Exclusions/Comments
Phlebotomy	Age	Adults only	All under 18s will need to attend their local Trust for their blood tests
	Mobility	Ambulant or partially ambulant patients	The facility does not have an access ramp for bedbound patients or patients requiring transport via trolley/stretcher. Patients who can transfer in and out of a wheelchair independently or with minimal assistance can be accepted. Patients requiring NHS Transport services cannot be accepted.
	Referral types	Any	All requests from NCL/Trusts within sector will be able to refer patient to the CDC. Patients must attend with their request form or should have had a referral made on Sunquest ICE
	Acuity	Independent	No patients who require their vital signs to be continuously monitored. Monitoring devices are not provided on site
	Referral Source	Any qualified referrer	Clinicians wishing to refer to the centre will need to complete a form which confirms medical and non-medical referrers as well as confirming the referral address to ensure they can be set up on systems.

Referral Routes

Requests will be accepted from any registered referral source across NCL.

Request Forms

The CDC encourages the use of referrals made on Sunquest ICE. All patients must be given a physical copy of the request form.

Directory of Service

All blood samples will be taken upon the receipt of an ICE request form

Appointments

Appointments will be made using the current SwiftQueue system.

Any urgent same day requests patient should go to the patient's local NHS Trust.

Sample Collections

Samples will be collected by a courier from this location throughout the day to ensure they are delivered to Pathology at the Whittington Health site at the following times for processing.

Days	**Collection from CDC**	**Delivery to WH-Pathology**	**Delivery to NMUH-Pathology**
Monday-Friday	11am	11.30am	11.30am
	2 pm	1.30pm	1.30pm
	5 pm	5.30pm	5.30pm
	7pm	6.30pm	6.30pm
	7.30pm	8.00pm	8.00pm
Saturday	10am	10.30am	10.30am
	1pm	1.30pm	1.30pm
	3pm	3.30pm	3.30pm
	5pm	5.30pm	5.30pm
Sunday	10am	10.30am	10.30am
	1pm	1.30pm	1.30pm
	3pm	3.30pm	3.30pm
	5pm	5.30pm	5.30pm

Post appointment administration

All samples will be receipted at the respective pathology department and will be processed according to the local protocols and results will be returned to the referrer following local protocols

Ophthalmology Service Description

Author: Safina Rashid Operational manager support for CDC, Head Orthoptist

Clinical Lead: Zine El Housseini

Personnel involved/consulted: Emma Calnan Ophthalmology Operations manager

Sign off: NCL Ophthalmology Board

Patient cohort

General Eligibility	Able to obtain good quality images – WF and OCT
General exclusion **- Defaulted to MR F2F clinic**	• Patients with cognitive impairment/dementia • Dense cataract • Unmanaged narrow angle patients/risk of angle closure Patients who are unable to transfer from wheelchair • Patient who are unable to independently mobilise
Conditions (All **follow up cases only** – only exception – new DR (non R3) referral from DESP with no non-DR pathology	• Mild to moderate NPDR ± DMO • Stable treated PDR – last PRP >12 months with evidence of regression post-PRP and stability • BRVO ± MO – no injection >6 months • Macroaneurysm • Other maculopathies – no treatment >6 months • Stable AMD • CSCR not requiring treatment • Hydroxychloroquine retinotoxicity monitoring • Choroidal naevus – at the discretion of the supervising consultant
Mobility	• The facility does not have an access ramp for bedbound patients or patients requiring transport via trolley/stretcher. Patients who can transfer in and out of a wheelchair independently or with minimal assistance can be accepted but patients requiring a hoist cannot.
Acuity	• No patients who require their vital signs to be continuously monitored. Monitoring devices are not provided on site

Diagnostic Pathways

Medical Retina

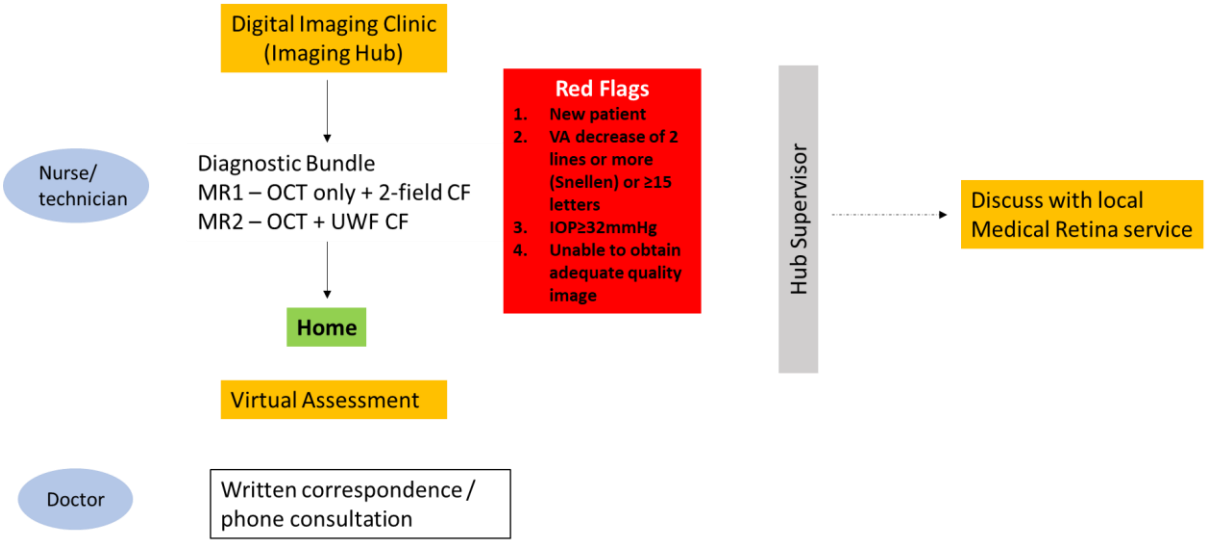


Figure 1: Clinical pathway for medical retina patients through the digital hub

1. There are three different diagnostic clinics;

    a. MR1 pathway (OCT only)
        i. Patients will undergo visual acuity assessment, intraocular pressure assessment with i-care, and dilation with only tropicamide 1.0%
        ii. A brief history will be obtained (Appendix 1)
        iii. Patients will then undergo Topcon OCT imaging of the macula and 2-field colour fundus image (macula centred and optic disc centred) using the colour fundus modality within the Topcon 3D 2000/Triton

    b. MR 2 pathway (WF+OCT)
        i. Patients will undergo visual acuity assessment, intraocular pressure assessment with i-care, and dilation with only tropicamide 1.0%
        ii. A brief history will be obtained (Appendix 1)
        iii. Patients will then undergo Topcon OCT imaging of the macula and ultra-widefield colour fundus photography

    c. MR 2 HCQ pathway (WF+OCT+AF)
        i. Patients will undergo visual acuity assessment, intraocular pressure assessment with i-care, and dilation with only tropicamide 1.0%
        ii. A brief history will be obtained (Appendix 1)

2. Diagnostic clinic procedure;
    a. Staff will confirm identity of patient
    b. History will be obtained by technician guided by Appendix 1
    c. Patient's preferred contact number documented in EMR
    d. Obtain visual acuity using Snellen or LogMAR
    e. Measure IOP using i-care
    f. Dilate both eyes with tropicamide 1.0% (provided no allergy to this)

g. Obtain retinal imaging as per pre-determined diagnostic bundle
h. Patients are informed they will receive written correspondence on their outcome. If urgent pathology is detected or further information is required, a phone call will be made.
i. Specific scenarios;
    i. If patient is driving
        i. Advise patient to have someone else take patient home
        ii. If not possible, wait until drops wear off
        iii. If patient refuses, continue with imaging in undilated eye and explain that patient may need another appointment if image quality is poor
    b. IOP;
        i. If IOP <24mmHg, continue as normal
        ii. If IOP >24mmHg, ≤32mmHg, don't dilate and continue with imaging undilated as above
        iii. If IOP >32mmHg
            1. Obtain support/advice

3. Immediate support/advice for technicians in the diagnostic clinic for urgent cases are as below (in this order);
    i. Senior technician/nurse in diagnostic hub
    i. Direct contact to corresponding hospital's MR on-call/clinical team

Eligibility

1. General eligibility for Medical Retina diagnostic clinics
    a. All **follow up cases only** – only exception – new DR (non R3) referral from DESP with no non-DR pathology

Glaucoma

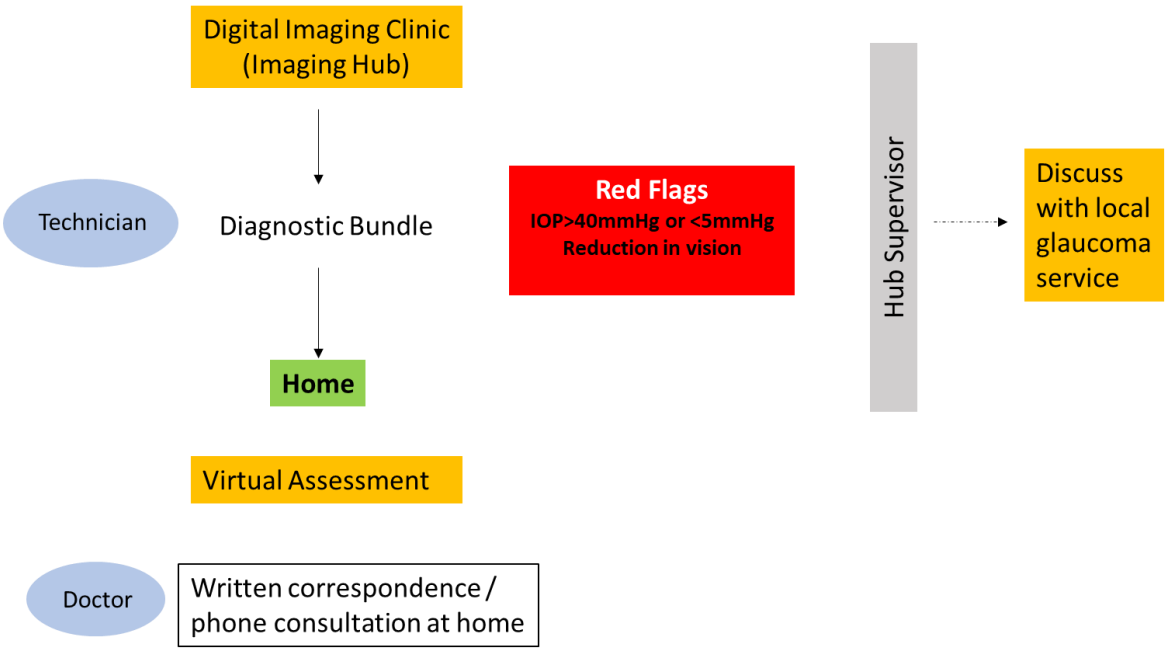


Figure 2: Clinical pathway for glaucoma patients through the digital hub

1. There are two diagnostic pathways (all assessments undilated)

    a. New patients pathway
        i. VA
        ii. IOP – ORA
        iii. Anterior segment OCT
        iv. Visual fields
        v. OCT
        vi. Auto-refraction (if VA <6/9)
        vii. Widefield fundus photography

    b. Follow up pathway
        i. VA
        ii. IOP – ORA
        iii. Visual fields
        iv. OCT
        v. Auto-refraction (if VA <6/9)

2. Diagnostic Clinic procedure
    a. New patients are called 1-5 working days before by optometrist and history taken in addition to script with COVID checks & data entered into OpenEyes
    b. Patient attends
    c. Checks in at desk (kiosk not to be used during pilot)
    d. Personal Data checked, including current phone number & address on PAS.
    e. For follow up patients, structured clinical questions to be asked by technician and added onto electronic medical records examination
        i. Which eyedrops (note if preservative free) are you currently using and for which eye(s) [using reference chart – appendix 2]
        ii. Have you been able to put your eyedrops in daily as instructed?
        iii. If not, when did you stop using the drops?
        iv. If so, what problems made you stop using your drops?
        v. Do you have any other problems with your eyes or vision to report?
    f. VA, ORA IOPcc and IOPg measured added into electronic medical records by technician

3. Immediate support/advice for technicians in the diagnostic clinic for urgent cases are as below (in this order);
        i. Senior technician/nurse in diagnostic hub
        ii. Direct contact to corresponding hospital's Glaucoma on-call/clinical team

Eligibility

1. Patients eligible for the glaucoma diagnostic imaging clinics are;
    a. New referrals that have been scrutinised by a consultant
    b. Follow-up patients that have been scrutinised by a consultant
    c. Post glaucoma medication changes
    d. Post SLT reviews
    e. Ocular hypertension/Glaucoma suspects
    f. Open angle glaucoma on medication
    g. Pseudophakic angle closure glaucoma on topical treatment

2. Patients who are not eligible for diagnostic imaging clinics;
    a. Previous glaucoma surgery
    b. Frail patients / Poor Mobility
    c. Post-op uncomplicated cataract surgery community pathways not established)
    d. Post LPI PAC(G)
    e. Reduction in visual acuity (eg cataract)
    f. Post-op cataract surgery in the presence of
        a. Functioning Bleb
        b. (Trabeculectomy/Xen/Preserflo)
        c. Advanced glaucoma
        d. Only eye
    g. Patients with learning difficulties / potential lack of capacity

Appendix

Appendix 1 – Medical Retina History guide for diagnostic hub technicians

New DESP referral

PAST OCULAR HISTORY

- Wearing glasses? Contact lenses?
- Any eye surgery in the past?
- Any previous issues with your eyes?
- Are you under any other eye clinics?

FAMILY OCULAR HISTORY

- Any of the family has glaucoma or any other eye conditions?

MEDICAL HISTORY

- Diabetes Type 1 / Type 2
- Any issues with your blood pressure and cholesterol?
- Any heart attacks or strokes?
- History of smoking?

MEDICATIONS

- Any recent changes to medications?

ALLERGIES

Follow up

ID confirmed: Yes / No

Patient has diabetes: Yes / No

Vision: Better / Stable / Worse

If worse: Gradual / Sudden

If sudden: duration?

Central distortion: Yes / No

Any heart attack or stroke in last 3 months: Yes / No

Pregnant: Yes / No / Not applicable

Preferred contact number:

Hydroxychloroquine retinotoxicity monitoring

Hydroxychloroquine Dose: ___ mg/day

Date started taking Hydroxychloroquine:

Duration of use:

Weight: ___ kg

Kidney Disease?: Yes / No

Tamoxifen use?: Yes / No

Appendix 2

Class	Drug Name / Generic	Brand Name	Obs	Posology
Prostaglandin Analogues	Latanoprost	Xalatan 0.005%		nocte
		Xalacom (with **Timolol 0.5%**)	C	**mane**
		Monopost	PF	nocte
	Travopost	Travatan		nocte
		DuoTrav (with **Timolol 0.5%**)	C	**mane**
	Tafluprost	Saflutan 0.15%	PF	nocte
		Taptiqom (with **Timolol 0.5%**)	C + PF	nocte
Prostamide	Bimatoprost	Lumigan (0.01%)		nocte
		Lumigan Single Dose (0.03%)	PF	nocte
		Ganfort (0.03% with **Timolol 0.5%**)	C	**mane**
		Ganfort Unit Dose (0.03% with **Timolol 0.5%**)	C + PF	**mane**
Carbonic anhydrase Inhibitors	Acetazolamide	Diamox 250mg		
		Diamox SR (Slow Release Capsules) 250mg		
	Dorzolamide	Trusopt 2%		tid/bd
		Cosopt (with **Timolol 0.5%**)	C	bd
		Cosopt Single Unit (with **Timolol 0.5%**)	C + PF	bd
	Brinzolamide	Azopt 1%		tid/bd
		Azarga (wth **Timolol 0.5%**)	C	bd
		Simbrinza (with **Brimonidine 0.2%**)	C	bd/tid
Beta Blockers	Timolol	Tiopex 0.1% gel	PF	**mane**
		Timoptol LA (Long Acting) 0.25%, 0.5%		**mane**
		Timoptol 0.25%, 0.5%		bd
	Betaxol	Betoptic 0.25%, 0.5%		bd
		Betoptic Single Dose 0.25%	PF	bd
	Carteolol	Teoptic 1%, 2%		bd
	Levobunolol	Betagan 0.5%		bd
		Betagan Unit Dose 0.5%	PF	bd
	Metripranolol	OptiPranolol UD 0.1%, (Pres. Free)	PF	bd
		OptiPranolol 0.3%		bd
Alpha Agonists	Brimonidine Tartrate	Alphagan 0.2%		bd/tid
		Combigan (with **Timolol 0.5%**)	C	bd
	Apraclondine	Iopidine 0.5%		bd/tid
		Iopidine Single Dose 1%		bd/tid
Cholinergic	Pilocarpine	Pilocarpine 1%		up to qds
		Pilocarpine 2% (PF)	(PF)	up to qds
		Pilocarpine 4%		up to qds

Source: https://www.medicines.org.uk/emc/

Obs: Combination of drugs **C**
Preservative Free **PF**

Chart 1: Eye drop reference chart

Appendix 3 – Directory of Service

Ultrasound services – Adults only

US Abdomen
US Abdomen and pelvis
US Abdomen and renal tract
US Bladder with flow rate
US Pelvis transabdominal
US Pelvis transvaginal
US Urinary tract

X-ray services – Adults only

Head and Neck	Upper Limb	Thorax	Abdomen	Pelvis	Lower Limb	Spinal Column	Other
XR Facial bones	XR Acromioclavicular joint Rt	XR Chest	XR Abdomen	XR Hip Both	XR Ankle Lt	XR Lumbar spine	XR Skeletal survey
XR Mandible	XR Clavicle Lt	XR Ribs Lt		XR Hip Lt	XR Ankle Rt	XR Thoracic spine	
XR Neck soft tissue	XR Clavicle Rt	XR Sternoclavicular joint Both		XR Hip Rt	XR Calcaneus Lt	XR Thoracolumbar spine	
XR Orbit foreign body demonstration Both	XR Elbow Lt	XR Sterno-clavicular Joints		XR Hips (Both)	XR Calcaneus Rt	XR Cervical spine	
XR Orbits FB	XR Elbow Rt	XR Sternum		XR Pelvis	XR Femur Lt	XR Whole spine	
XR Post nasal space	XR Finger index Lt			XR Pelvis and hip left	XR Femur Rt		
XR Skull	XR Finger index Rt			XR Pelvis and hip right	XR Foot and ankle Left		
XR Temporoman-dibular joint Rt	XR Finger little Lt			XR Sacroiliac joint Both	XR Foot and ankle Right		
	XR Finger little Rt			XR Sacro-Iliac Joints	XR Foot Both		
	XR Finger middle Lt			XR Sacrum	XR Foot Left		
	XR Finger middle Rt				XR Foot Lt		
	XR Finger ring Lt				XR Foot Right		
	XR Finger ring Rt				XR Foot Rt		
	XR Fingers Lt				XR Knee Both		
	XR Fingers Rt				XR Knee Lt		
	XR Hand Lt				XR Knee Rt		
	XR Hand Rt				XR Patella Lt		
	XR Humerus Lt				XR Patella Rt		
	XR Humerus Rt				XR Tibia and fibula Left		
	XR Radius and ulna Lt				XR Tibia and fibula Right		
	XR Radius and ulna Rt				XR Toe great Lt		
	XR Scaphoid Lt				XR Toe great Rt		
	XR Scaphoid Rt				XR Toes Lt		
	XR Scapula Lt				XR Toes Rt		