AECC University College
Bournemouth
Open Upright MRI

MRI Referral Form

Please note- we are unable to accept referrals for contrast enhanced MRI scans
All scans must be paid for before departure

Patient Details

Mr, Mrs, Miss, Dr, Other (please specify):			GP:
First name:			Practice Name and Address:
Surname:			
Date of birth:	Male ○	Female ○	Tel: Fax:
Tel: Home	Mobile		
Email:			
Address:			
Does the patient have any special requirements e.g. require an interpreter, oxygen or a wheel chair? *Please provide details*			

Relevant clinical detail

Please provide as much relevant clinical information as possible

Patient weight:
Patient height: **Claustrophobic? Yes / No** (please circle)

Investigation(s) Required

Tick investigation required; please indicate which side of the body and body part where appropriate.

Knee	L ○	R ○	Lumbar spine ○	Lumbar spine + Lumbar spine weight-bearing Yes ○	Brain ○		
Ankle	L ○	R ○		Lumbar spine +Lumbar spine in flexion and extension Yes ○	Shoulder	L○	R○
Foot	L ○	R ○	Cervical spine ○	Cervical spine + Cervical spine in flexion and extension Yes ○	Wrist	L○	R○
Sacro-Iliac Joints ○			Thoracic spine ○	Thoracic spine + Thoracic spine weight-bearing Yes ○	Hand	L○	R○

Safety check as recommended by the MHRA, the referring clinician is required to assess the patient safety for MRI scans

Does the patient have any implanted metallic devices? (e.g. cardiac pacemaker, artificial heart valve, cerebral aneurysm clips, neurotransmitter, cochlear implant etc.)	Yes ○	No ○
Is the patient known to have metallic fragments in their eyes? *If yes, it is mandatory to exclude metal foreign bodies in the eyes by orbital X-Ray. If a metallic foreign body is detected, unable to proceed with MRI.*	Yes ○	No ○
Has the patient had surgery in the last 8 weeks?	Yes ○	No ○
Is the patient pregnant? *If yes, please contact Bournemouth Open Upright MRI*	Yes ○	No ○

Referring Clinician's details

Mr, Mrs, Miss, Dr, Other (please specify):			
Referrer name:			
Speciality/Profession:	Regulatory Body Registration Number (e.g. GMC, GCC, HCPC etc.):		
Hospital/Practice Name:	How would you like to receive the report?	Post ○	Fax ○
Address: Tel: Fax: Email:	Do you want the report sent to an additional clinician? *If yes, please give details*	Yes ○	No ○
Emergency contact number:	Signature:	Date:	

Please post or fax this form to: **Bournemouth Open Upright MRI, 13-15 Parkwood Road, Bournemouth BH5 2DF** **Fax 01202 422009**

Official use only	
MRI checked and authorised by:	
Appointment date/time:	
Cost:	