AECC University College Bournemouth
Open Upright MRI

MRI Referral Form

Please note that 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): First Name:		Surname:
Date of birth:	Male O Female O	Tel: Home Mobile
Address Email:		
Does the patient have any special requirements e.g. require an interpreter, oxygen or a wheel chair? *Please proved details*		
Relevant clinical detail Please proved 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 part where appropriate. (please note that weight bearing will incur extra costs)

Knee	L O	R O	Lumbar spine O	Lumbar spine **AND** Lumbar spine weight bearing	Yes O	Shoulder	L O	R O	Brain O
Ankle	L O	R O		Lumbar spine **AND** Lumbar spine in flexion and extension	Yes O	Wrist	L O	R O	
Foot	L O	R O	Cervical Spine O	Cervical spine **AND** Cervical spine in flexion and extension	Yes O	Hand	L O	R O	
Sacroiliac joints O			Thoracic spine O	Thoracic spine **AND** Thoracic spine weight bearing	Yes O	Elbow	L O	R O	

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 O	No O
Is the patient know 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 O	No O

Referring Clinician's details

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

Please post or fax this form to: Bournemouth Open Upright MRI, Parkwood Campus, Parkwood Road, Bournemouth BH5 2DF Fax 01202 422009
For any further information please telephone 01202 436276

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