

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 <input type="radio"/> Female <input type="radio"/>		Tel: Home		Mobile						
Address												
Email:												
Does the patient have any special requirements e.g. require an interpreter, oxygen or a wheel chair? <i>Please provide details</i>												
Relevant clinical detail				Patient weight:			Patient height:			Claustrophobic? Yes/No (Please circle)		
Please provide as much relevant clinical information as possible												
Investigation(s) Required												
Tick investigation required; please indicate which side of the body where appropriate. (please note that investigations in BOLD will incur additional costs)												
Knee	L <input type="radio"/>	R <input type="radio"/>	Lumbar spine <input type="radio"/>	Lumbar spine AND Lumbar spine weight bearing			Yes <input type="radio"/>	Shoulder	L <input type="radio"/>	R <input type="radio"/>	Brain <input type="radio"/>	
Ankle	L <input type="radio"/>	R <input type="radio"/>		Lumbar spine AND Lumbar spine in flexion and extension			Yes <input type="radio"/>	Wrist	L <input type="radio"/>	R <input type="radio"/>		
Foot	L <input type="radio"/>	R <input type="radio"/>	Cervical Spine <input type="radio"/>	Cervical spine AND Cervical spine in flexion and extension			Yes <input type="radio"/>	Hand	L <input type="radio"/>	R <input type="radio"/>		
Sacroiliac joints	<input type="radio"/>		Thoracic spine <input type="radio"/>	Thoracic spine AND Thoracic spine weight bearing			Yes <input type="radio"/>	Elbow	L <input type="radio"/>	R <input type="radio"/>		
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 <input type="radio"/>	No <input type="radio"/>		
Is the patient known to have metallic fragments in their eyes? <i>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.</i>									Yes <input type="radio"/>	No <input type="radio"/>		
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:					Report and images will be sent directly to the referrer via IEP Anyone							
Address					To facilitate this please provide:							
Tel:					1. Email address:							
Fax:					2. Mobile number or Additional email address:							
Email:												
Emergency contact number:					Signature			Date				