



PATIENT DETAILS

Name: _____

Male

Female

Date of Birth: _____

Start date of last Menstrual Period (if applicable) _____

Address: _____

Patient arrival: Trolley Wheelchair Walking

Funding: Self Funded Private Patient

_____ Postcode: _____

Patient's insurance company: _____

Tel: _____

Membership number: _____

Mobile: _____

Pre-authorisation number (if known) _____

Email: _____

Please Note: Uninsured patients & patients without pre-authorisation are required to pay on the day of their appointment.

REFERRAL INFORMATION

MRI CT X-Ray Ultrasound

Reason for referral:

Area to be imaged:

Date of test: _____

RELEVANT PREVIOUS MEDICAL HISTORY

Details (including any surgery & current medication):

Please include copies of any recent X-rays or scan reports

SAFETY CHECK

Could the patient be pregnant? Y N

Is the patient breast feeding? Y N

Is the patient a high infection risk? Y N

If YES, please specify: _____

Is the patient diabetic? Y N

Is the diabetes controlled by: Diet Insulin Tablet

Is the patient on Metformin? Y N

Does the patient have allergies? Y N

If YES, please specify: _____

TO BE COMPLETED FOR ALL MRI EXAMINATIONS

MRI Contraindications - does the patient have:

A pacemaker? Y N

A cerebral aneurysm clip? Y N

Cochlear implants? Y N

Neurostimulators Y N

Programmable hydrocephalus shunt? Y N

Metallic foreign body in eye? Y N

Other metallic implants? Y N

REFERRING CLINICIAN'S DETAILS

IR(ME)R 2000 regulations require this form to be signed by the referring Clinician

Consultant name: _____

Signature: _____

Date: _____

_____/_____/_____

Address: _____

_____ Postcode: _____

Tel: _____ Mobile: _____

Email: _____