

MRI referral form

In signing and requesting the MRI referral for the above patient I have understood the contraindications for MRI scans and,

where requested, the implications and side effects associated with the administration of intravenous Gadolinium.

Referring clinician's details

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

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

Region(s) to be scanned

Relevant clinical details

Patient details

Signature:Date:

Email

Mobile:

Tel home

Self-pay / Insured

Insurers name

Policy number

Emergency contact no.

Postcode

Address

If ‘yes’ – it is mandatory to exclude metallic orbital foreign bodies by orbital X-ray. If no metallic foreign body is detected, scan can proceed. If detected, unable to proceed

Y / N

Is there a history of metallic foreign bodies in the patients eye?

Urgent scan? Yes / No



Please confirm how you would like to receive the report by circling below:

 **Email Post FAX**

Do you want the report sent to another clinician?

If yes please give full details:

Region(s) to b scanned

Fax

Tel

Email

Postcode

Address

Hospital / practice

Specialty / profession

Referrer name

Mr Mrs Miss Dr Other (please specify)

Does the patient have a cardiac pacemaker?

Does the patient have an intracranial aneurysm clip or a programmable ventriculoperitoneal shunt?

Does the patient have renal impairment?

Has the patient had a cochlear implant or neurotransmitter?

MHRA guidelines recommend all patients (particularly those over 65) should be screened for renal dysfunction by obtaining a history, laboratory testing or both

Additional requirements**: 3T MRI MpMRI Prostate**

If ‘yes’ – an extrapolated GFR should be determined from the serum creatinine and discussed with our radiologist / radiographers

If ‘yes’ – unable to proceed with scan

If ‘yes’ – unable to proceed with scan

If ‘yes’ – unable to proceed with scan

Relevant previous imaging None / Film / Digital **Date:**

Y / N

Y / N

Y / N

Y / N

Date of birth

Male /Female

Surname

Mr Mrs Miss Dr Other (please specify)

First name

**Is Gadolinium required? Yes**/ No