IMAGING REQUEST FORM

MEDICAL IMAGING PARTNERSHIP

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ALL SECTIONS MUST BE COMPLETED BY THE REFERRER

PATIENT INFORMATION: Please complete form in CAPITALS using black ink and ticking/deleting as appropriate.

Title:	Surname:	Forename:	Date of Birth:
Address:			Postcode:
Tel:	Mob:	Email:	
Insurer:	Policy No:	Pre-Auth. No:	
Self-funding		Male ◯	Female ◯

MRI APPOINTMENT:

Date:	Time:	Preferred Radiologist: Dr

EXAMINATION REQUESTED:

CLINICAL INDICATION FOR EXAMINATION:

Please summarise relevant history, clinical findings and test results. Indicate the question that the examination should answer.

CONTRAINDICATIONS: Does the patient have any of the following possible contraindications to 3T MRI (tick if relevant)

◯ Cardiac Pacemaker	◯ Cardiac Stent	◯ Aneurysm Clip	◯ Prosthetic Heart Valve
◯ Bilateral Implants (Knees/Hips)	◯ Metallic Fragment in Eye	◯ Cochlear Implant	◯ Any Metallic Implants
◯ Recent Surgery in last 6 weeks	◯ Contraceptive Coil	◯ Within first trimester of pregnancy	

IMPORTANT: If the answer is YES to the following, Serum Creatinine levels must be provided:

Is there a history of kidney disease/surgery?	Yes	No ◯	Is there a history of dialysis?	Yes ◯	No ◯
Is the patient aged 65yrs or over?	Yes	No ◯			

Serum creatinine /eGFR /	Date measured:

REFERRING CONSULTANT/GP - **Please complete the following information:**

Referred By:	Signature:	Date:
Hospital/Clinic:	Tel No:	Fax No:
Email Address:	Date report required:	