

Request for MRI Scan



Patient number:	
WLI number:	

Referrers are required to complete sections 1-4 accurately and legibly. Inadequately completed forms will not be accepted.

1 - Patient details

Title:		Forename:		Surname:	
DOB:		Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Address:					
Postcode:		Tel (Home):		Mobile:	

Patient Identification For Kingsbridge Private Hospital use only.	I have confirmed the above patient's name, address and DOB. Signed:	<input type="text"/>
	Verified by patient: <input type="checkbox"/> If another/status:	<input type="text"/> Signed: <input type="text"/>

2 - To be completed by referring Clinician - area to be scanned

<input type="checkbox"/> Brain	<input type="checkbox"/> Whole spine	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Abdomen
<input type="checkbox"/> Brain & cervical spine	<input type="checkbox"/> Brachial plexus	<input type="checkbox"/> Elbow	<input type="checkbox"/> Pelvis
<input type="checkbox"/> Brain & whole spine	<input type="checkbox"/> Ankle	<input type="checkbox"/> Wrist	<input type="checkbox"/> Other (please specify):
<input type="checkbox"/> Cervical spine	<input type="checkbox"/> Foot	<input type="checkbox"/> Internal auditory canals	<input type="text"/>
<input type="checkbox"/> Thoracic spine	<input type="checkbox"/> Hip	<input type="checkbox"/> Pituitary gland	
<input type="checkbox"/> Lumbar spine	<input type="checkbox"/> Knee		

3 - Clinical details **Note:** Please include provisional diagnosis or indication and indicate results of previous tests/imaging if applicable. Please detail any previous relevant surgery the patient may have had.

For Gadolinium based contrast studies is there a history of:

<input type="checkbox"/> Hypertension	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Gout	<input type="checkbox"/> Renal disease/surgery	<input type="checkbox"/> Over 65	<input type="checkbox"/> Liver disease
---------------------------------------	-----------------------------------	-------------------------------	--	----------------------------------	--

If YES to any of the above, it is essential to supply the following:

Serum Creatinine:	<input type="text"/>	eGFR:	<input type="text"/>	Date checked:	<input type="text"/>
-------------------	----------------------	-------	----------------------	---------------	----------------------

4 - Referrer

Referrer (print name):		Signature:		Date:	
Address:				Post Code:	

CONTRA-INDICATIONS TO MRI: Due to the strong magnetic fields present, certain patients cannot undergo MR scanning. Patients with cardiac pacemakers, defibrillators, neuro-stimulators, intracranial aneurysm clips and intra-orbital foreign bodies are contraindicated for MRI. Certain heart valves, stents, shunts and other implantable ferromagnetic or electrical devices may also not be suitable for scanning. Please contact the MRI unit if you have any queries about your patient's suitability for MR scanning.

Please send completed form by post, fax or email to:
Kingsbridge Private Hospital, MRI, CT and Outpatients Centre, 801 - 805 Lisburn Road, Belfast, BT9 7GX.
T: +44 (0) 28 9073 5272 | F: +44 (0) 28 9024 9929 | E: imaging@3fivetwo.com

