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| **MRI IMAGING REQUEST FORM** | | | **Enquiry Line: 01482 674080 HRI** | | |
| *Received date:* | | *Breach Date:* | | | *Appoint Date, Time, Room & Site:* |
| **Referring Practice:** | | **Name of referrer:** | | |
| PRACTICE (B) CODE: | | **Direct telephone number of person referring:** | | |
| **Practice Tel No:** | | **Patient NHS/Hospital Number:** | | | |
| **Patient Surname**: | | **First Name:** | | | **DOB:** |
| **Preferred Contact Number (Patient):** | | **Address:** | | | |
| **Alternative Contact Number:** | | **Examination Requested:** | | | |
| **Clinical Question Posed: (please state the problem and the questions to be answered)** | | | | | |
| **Any relevant issues we need to know: i.e. mobility issues, transport issues, excessive BMI, allergies, communication barriers (i.e. sign language or interpreter services required)? Please provide details:** | | | | | |
| **Does the patient have any MRI contraindications?**   * Do they have a pacemaker or defibrillator? Yes No * Have they had heart surgery or heart valve replacement? Yes No * Have they had surgery to their head/eyes/ears/spine? Yes No * Have they ever had a brain haemorrhage/aneurysm clip? Yes No * Does the patient have any stents? Yes No * Have they had an operation in the last 6 weeks? Yes No * Have they ever had a penetrating eye injury involving metal? Yes No * Do they have any artificial implanted devices? Yes No * Is the patient pregnant? Yes No * Is there any renal impairment? Yes No * If yes, what is the current GFr?   **This request card will not be accepted without these questions completed.** | | | | | |
| **If the answer is yes to any of the above, please provide further information:** | | | | | |
| Vetted Code: | Priority: | | | Vetter initials: | |

**REFERRERS: PLEASE COMPLETE ALL BOXES BELOW & UPLOAD ONTO ERS**

**PLEASE DO NOT CHANGE ANY OF THE HEADINGS**