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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**