

MRI REQUEST FORM

PLEASE NOTE - WE ARE UNABLE TO ACCEPT REFERRALS FOR PATIENTS UNDER 18 YEARS OF AGE
PLEASE NOTE - WE ARE UNABLE TO ACCEPT REFERRALS FOR BREAST MRI

<p>Patient ID</p> <p>NHS Number _____</p> <p>First Name _____</p> <p>Surname _____</p> <p>Address _____</p> <p>_____</p> <p>_____ Post Code _____</p> <p>Date of Birth _____</p> <p>Telephone (Home) _____</p> <p>Telephone (Work) _____</p> <p>Telephone (Mobile) _____</p> <p>Email Address _____</p> <p>Gender Male <input type="checkbox"/> Female <input type="checkbox"/></p>	<p>Referring Clinician</p> <p>Name _____</p> <p>GMC/HPC/NMC No. _____</p> <p>Address _____</p> <p>_____</p> <p>_____ Post Code _____</p> <p>Referring PCT Code _____</p> <p>Referring Practice Code _____</p> <p>Telephone No. (For urgent clinical findings) _____</p> <p>Fax No. _____</p> <p>NHS Mail (nhs.net only) _____</p>
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<p>Physical/Communication difficulties (Specify if any) _____</p> <p>_____</p> <p>If interpreter required, language _____</p> <p>Religion _____</p> <p>Ethnicity _____</p>	<p>Eligible for NHS Funded Transport Yes <input type="checkbox"/></p> <p>Car Transport Required Yes <input type="checkbox"/></p> <p>Wheelchair User Yes <input type="checkbox"/></p> <p>The patient must be ambulant, or if a wheelchair user they must be able to transfer independently on to the scanner or examination couch.</p>
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Investigation Required & Provisional Diagnosis	
Lumbar Spine	Radiculopathy (indicate side) with neurological deficit that has not responded to conservative treatment or is demonstrating severe and progressive motor loss <input type="checkbox"/>
	Other reason (specify) _____ <input type="checkbox"/>
Knee	Suspected meniscal tear <input type="checkbox"/>
<input type="checkbox"/> L <input type="checkbox"/> R	Suspected ligament damage <input type="checkbox"/>
	Knee pain where arthroscopy considered <input type="checkbox"/>
	Other reason (specify) _____ <input type="checkbox"/>
Shoulder	Impingement <input type="checkbox"/>
<input type="checkbox"/> L <input type="checkbox"/> R	Instability <input type="checkbox"/>
	Rotator cuff tear <input type="checkbox"/>
	Other reason (specify) _____ <input type="checkbox"/>
Head	Persistent headaches <input type="checkbox"/>
	Other reason (specify) _____ <input type="checkbox"/>
Other area (specify) _____	

All clinicians must complete the following MRI Safety Questionnaire	
1. Does the patient have any implanted metallic foreign devices? (e.g. cardiac pacemaker, artificial heart valve, cerebral aneurysm clips, cochlear implant etc)	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Is the patient known to have metallic fragments in their eyes?	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Is the patient known to have renal impairment (eGFR <30)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Does the patient have any allergies?	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. Has the patient had any previous surgery in the last 2 years? If yes, please give details:	Yes <input type="checkbox"/> No <input type="checkbox"/>

Is there any possibility of the patient being pregnant?	
Date of last menstrual period ___/___/_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
Breast Feeding	Yes <input type="checkbox"/> No <input type="checkbox"/>

Referrer's Signature	Date of request ___/___/_____
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