

Radiology Department, 15 Portland Place, London W1B 1PT

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PATIENT INFORMATION

LAST NAME		FIRST NAME	
DATE OF BIRTH		FEMALE / MALE	M <input type="checkbox"/> F <input type="checkbox"/>
INTERPRETER REQUIRED?		PHONE NUMBER	
PATIENT'S ADDRESS		EMAIL	
		FUNDING	SELF PAY <input type="checkbox"/> INSURANCE <input type="checkbox"/> CORPORATE ACCOUNT <input type="checkbox"/> OTHER <input type="checkbox"/>
		INSURANCE COMPANY	
		MEMBERSHIP NUMBER	
		Pre- authorisation number	

 MRI MAMMOGRAPHY CT ULTRASOUND DXA X-Ray

Exam requested:

Clinical Indication:

Including any relevant history and investigations

Preferred Radiologist

Investigation

 Could the Patient be Pregnant? Yes No

 Is the patient breast feeding? Yes No

 Is the patient a high infection risk? Yes No

If yes, please specify

 Does the patient have any allergies? Yes No

If yes, please specify

Creatinine level

eGfr and date

TO BE COMPLETED FOR ALL MRI EXAMINATIONS
MRI Contraindications- does the patient have:

 A pacemaker? Yes

 A cerebral aneurysm clip? Yes

 Cochlear implants? Yes

 Neurostimulators? Yes

 Programmable hydrocephalus shunt? Yes

 History of working with metal? Yes

 Metallic foreign body in eye? Yes

 Other Metallic implants Yes
NB: If Yes to any of the details please inform the Imaging Department prior to the examination
REFERRING CLINICIAN DETAILS –IR(ME)R 2017 regulations require this form to be signed and dated by the referring clinician. Incomplete forms will be rejected and returned. The radiation risks must be balanced against potential benefit to the patient.

Name		Address	
Signature		Tel	
Date		Email	