Request for MRI Scan

Patient No. _____

WLI No._____

3fivetwo™ HEALTHCARE

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

1 Patient Details

Surname: _____ Forename: _____ Title: _____

Date of Birth: _____ Gender: Male / Female (Delete as appropriate)

Address: _____

_____

Post Code: _____ Tel (Home): _____ Mobile: _____

Patient Identification: For operator use only.

I have confirmed the above patients name, address and DOB. Signed: _____

Verified by patient: ☐ If another / Status: _____ Signed: _____

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

Brain	☐	Whole spine	☐	Shoulder	☐	Abdomen	☐
Brain & cervical spine	☐	Brachial plexus	☐	Elbow	☐	Pelvis	☐
Brain & whole spine	☐	Ankle	☐	Wrist	☐	Other (please specify)	
Cervical spine	☐	Foot	☐	Internal auditory canals	☐		
Thoracic spine	☐	Hip	☐	Pituitary gland	☐		
Lumbar spine	☐	Knee	☐				

3 Clinical Details:

notes: Please include provisional diagnosis or indication and indicate results of previous tests / imaging if applicable.

For Gadolinium based contrast studies is there a history of:

Hypertension ☐ **Diabetes** ☐ **Gout** ☐ **Renal Disease/Surgery** ☐ **Over65** ☐ **Liver Disease/Transplant** ☐

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

SERUM CREATININE_____ eGFR_____ DATE CHECKED_____

4

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, nero-stimulators, intracranial aneurysm clips and intra-orbital foreign bodies are contra-indicated 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.

For operator / practitioner use only

Examination / procedure authorised by: _____ Date: _____

(subject to a decision to proceed following completion of patient safety questions)

Appointment Date: _____ Time: _____

Please send by post or fax to: **3fivetwo Healthcare** Medical Imaging Centre, 6 Lisburn Road, Belfast BT9 6AA **T** +44 (0)28 9073 5266 **F** +44 (0)28 9024 9929 **E** imaging@3fivetwo.com

MRI

For operator / practitioner use only

Patient Safety Questions:

Does the patient have:

Cardiac pacemaker Yes ☐ No ☐

Intra-cranial clips / shunts Yes ☐ No ☐

Intra-orbital metallic fragments Yes ☐ No ☐

Is the patient pregnant? Yes ☐ No ☐

LMP Date: _____

Implant of any type (e.g. cochlear, neurostimulator, ocular, joint prosthesis, heart valve) Yes ☐ No ☐

If yes: Make: _____

Model: _____

Date implanted: _____

Pharmaceutical prescription & contrast Administration

Name:	Strength:	Dose / quantity:	Batch no. & Expiry date:	Drawn up by:	Checked by:
Prescribers signature:			Administered by:		

Examination / Procedure details

Date	Examination	SOP (🕐)	PROTOCOL	Radiologist(s)
				Operator(s)

Scan reporting & dispatch

Assigned to (Radiologist): _____ ☐ Report Sent ☐ Disc Sent Date Sent: _____

Address sent to: _____

Notes:

For 352 Admin use: This patient is: ☐ Insured ☐ Self Funding ☐ Waiting List Initiative ☐ Employer ☐ Occ Health / Screen

Insurance Company / Trust: _____

Policy Number: _____ Authorisation Number: _____

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MRI