

Imaging Request Form



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Patient details										Scan appointment details				Next appointment with referrer							
Title										Date				Date							
Surname										Time				Time							
Forename																					
Preferred name																					
DOB	D	D	M	M	Y	Y	Y	Y													
Sex																					
<input type="checkbox"/> Male										<input type="checkbox"/> Female				<input type="checkbox"/> Other							
Address																					
Postcode																					
Email																					
Phone No. / Mobile																					
Wheelchair User										YES <input type="checkbox"/> NO <input type="checkbox"/>				Hoist Req.				YES <input type="checkbox"/> NO <input type="checkbox"/>			
Interpreter Req.										YES <input type="checkbox"/> NO <input type="checkbox"/>				If YES Language							
										Payment information											
										Please tick				<input type="checkbox"/> NHS				<input type="checkbox"/> Embassy			
														<input type="checkbox"/> Self-Pay				<input type="checkbox"/> Sponsor			
														<input type="checkbox"/> Insured				<input type="checkbox"/> Medico-legal			
										Payment Provider											
										Membership No.											
										Authorisation Code											

MRI contraindications To be completed by the referring clinician.

Cardiac Pacemaker	YES <input type="checkbox"/> NO <input type="checkbox"/>	Aneurysm Clip	YES <input type="checkbox"/> NO <input type="checkbox"/>	Metallic Foreign Body in the Eye	YES <input type="checkbox"/> NO <input type="checkbox"/>
Hydrocephalus Shunt	YES <input type="checkbox"/> NO <input type="checkbox"/>	Previous Neurosurgery	YES <input type="checkbox"/> NO <input type="checkbox"/>	Any Possibility of Pregnancy	YES <input type="checkbox"/> NO <input type="checkbox"/>
Diabetic	YES <input type="checkbox"/> NO <input type="checkbox"/>	Cochlear Implant	YES <input type="checkbox"/> NO <input type="checkbox"/>	Ingestible Camera/PillCam	YES <input type="checkbox"/> NO <input type="checkbox"/>
Infectious	YES <input type="checkbox"/> NO <input type="checkbox"/>	Any Renal Impairment	YES <input type="checkbox"/> NO <input type="checkbox"/>	Creatinine/eGFR:	Date:

Examination requested MRI Ultrasound

Clinical information

Review of prior imaging required? YES NO If YES, details: _____

Referring clinician

Name					Signature				
GMC/HCPC Number					Date				
D	D	M	M	Y	Y	Y	Y		
Name - Hospital/Practice									
Address									
Postcode									
Telephone					Email				
Results to be sent by					Images to be sent using IEP				
<input type="checkbox"/> Post <input type="checkbox"/> Email					YES <input type="checkbox"/> NO <input type="checkbox"/>				