



MRI Request Form

MRI Department, Direct Line (020) 7460 5611 / 5612

MRI Department, Direct Fax (020) 7835 2492

PLEASE BRING THIS FORM WITH YOU WHEN YOU ATTEND THE HOSPITAL
All sections of this form must be fully completed

Appointment

Date _____ Time _____
Referring Consultant _____
Report / CD to: _____

Patient Details:

Place Sticker Here

Name: _____

DoB: _____

Hospital No: _____ Sex: M F

Pregnant : Y / N

LMP _____ Signature _____

CONTRAINDICATIONS - Referring Clinician Declaration

Does the patient have? :-

	Y	N
A Cardiac Pacemaker?		
A Cochlear Implant		
Metallic Fragments in Eye		
Any Metallic Implants?		
1 st Trimester Pregnancy		
Other		

If YES, please give details, Make & Model

PATIENT TO BRING PREVIOUS X-RAYS OR SCANS

EXAMINATION REQUIRED: _____ CHARGE CODE _____

CONTRAST REQUIRED? YES _____ NO _____

PRIOR TO MR CONTRAST ADMINISTRATION

PLEASE TICK ALL THAT APPLY

	Yes	No
Is the patient 65 years or over?		
Is the patient 16 years or under?		

	Yes	No
Is there a history of kidney disease / surgery?		
Is the patient on dialysis?		

If YES to any of the above, GFR should be measured prior to attendance

Serum creatinine / estimated GFR _____
Date Measured _____

CLINICAL INDICATION / HISTORY AND REASON FOR EXAM:

What clinical question do you require answering?

Examinations **CANNOT** be performed without sufficient relevant clinical information and a Doctor's signature.

GA Requirements: Please be advised that special arrangements need to be made for all GA and Paediatric patients. Please phone the MRI department. Patients or referrers who wish to discuss any aspects of their examination including the above contraindications should contact the MRI Dept.

Authorised by _____ Date _____
Operator _____ Date _____

Referring Clinician Signature
Signature _____ Date _____

Guidance Notes for Referrers

In accordance with the *Ionising Radiation (Medical Exposures) Regulation 2000*, the Bupa Cromwell Hospital Radiology Department would like to make all Referrers aware of the following Guidelines:

Referrals:

A request for a Radiological Examination will be regarded as a request from one Clinician or Health Professional to the Radiology Department for an opinion based upon a radiological examination to assist in the management of a clinical problem.

Diagnostic Imaging or radiological procedures will only be performed upon a written request signed by a Registered Medical or Dental Practitioner or by an authorised Non-Medical Practitioner

Signed referrals (request form or letter) must precede or accompany the patient. Signed faxes are also accepted

All requests must carry sufficient information to identify the patient. This normally consists of first name, middle name if any, and family name, date of birth and address.

All requests must carry sufficient clinical information to enable the requested examination to be justified. Referral criteria are based on the Royal College of Radiologists' Guidelines - "Making the best use of a Department of Clinical Radiology : Guidelines for Doctors".

All requests shall clearly state the examination requested.

All requests must include contact details of the Referring Clinician including address and telephone number.

Females of Childbearing Age (12-55 years)

All requests for MRI examinations for females of childbearing age (12-55 years) must state the date of the first day of the patient's menstrual period

Clinical Justification of Requests:

All requests for imaging will be assessed prior to exposure by the appropriate Practitioner for the examination to ensure that they meet with The Royal College of Radiologists' Guidelines and any local Guidelines and that, in their professional judgement, they are clinically justified (*Royal College of Radiologists Publication: BCFR(00)5*).