# Request for MRI Scan

KINGSBRIDGE Private Hospital

| | |
|---|---|
| Patient number: | |
| WLI number: | |

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

## 1 - Patient details

| | | | | | |
|---|---|---|---|---|---|
| Title: | | Forename: | | Surname: | |
| DOB: | | Gender: ☐ Male ☐ Female | | | |
| Address: | | | | | |
| Postcode: | | Tel (Home): | | Mobile: | |

**Patient Identification**
For Kingsbridge Private Hospital use only.

I have confirmed the above patient's name, address and DOB. Signed:

Verified by patient: ☐ If another/status: Signed:

## 2 - To be completed by referring Clinician - area to be scanned

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

## 3 - Clinical details

**Note:** Please include provisional diagnosis or indication and indicate results of previous tests/imaging if applicable. Please detail any previous relevant surgery the patient may have had.

**For Gadolinium based contrast studies is there a history of:**

☐ Hypertension ☐ Diabetes ☐ Gout ☐ Renal disease/surgery ☐ Over 65 ☐ Liver disease

**If YES to any of the above, it is essential to supply the following:**

Serum Creawtinine: eGFR: Date checked:

## 4 - Referrer

| | | | | | |
|---|---|---|---|---|---|
| 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 contraindicated 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.

**Please send completed form by post, fax or email to:**
**Kingsbridge Private Hospital**, MRI, CT and Outpatients Centre, 801 - 805 Lisburn Road, Belfast, BT9 7GX.
T: +44 (0) 28 9073 5272 | F: +44 (0) 28 9024 9929 | E: imaging@3fivetwo.com



MRI

| For operator/practioner use only | Examination/procedure authorised by: | Date: |
|---|---|---|
| | (Subject to a decision to proceed following completion of pregnancy status section on reverse, if relevant.) | |

## 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 |

Date of LMP:

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

If **YES**:

| | |
|---|---|
| Make: | |
| Model: | |
| Date implanted: | |

### Pharmaceutical prescription and contrast administration

| Name: | Strength: | Dose/QTY: | Batch # & Exp. date: | Drawn up by: | Checked by: |
|---|---|---|---|---|---|
| | | | | | |
| Prescriber's signaure | | | Administed by: | | |

### Examination/procedure details

| Date: | Examination: | SOP (🕒): | Protocol: | Radiologist(s): |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | Operator(s): |
| | | | | |
| | | | | |
| | | | | |

## Scan reporting and dispatch

| Assigned to (Radiologist): | | ☐ Report sent ☐ Disc sent | Date: | |
|---|---|---|---|---|
| Address sent to: | | | Post Code: | |

Notes

| For Kingsbridge Private Hospital admin use: | **This patient is:** |
|---|---|

☐ Insured ☐ Self funding ☐ WLI ☐ Employer ☐ Occ Health/Screen

Insurance company/trust:

Policy Number: Authorisation number:

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