 REFERRAL FORM

#  PATIENT DETAILS

Mr Mrs Miss Dr Other (please specify):

Please state which preferred site or tick if any site is acceptable[ ]

First name:

Surname:

Date of birth:

[ ] Male [ ] Female

Email:

Telephone:

Address:

Post code:

Policy number:

Authorisation code:

Self-pay/Insured:

Insurer name:

#  RELEVANT CLINICAL DETAILS

**\***Region(s) to be scanned:

**\***Justification for scan:

**\*Please ensure these boxes are completed**

MRI[ ]  Ultrasound[ ]  Echo[ ]  X-Ray[ ]  24hr BP monitoring[ ]  CT[ ]  12hr ECG[ ]  24hr ECG[ ]  48hr ECG[ ]  DEXA[ ]

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Additional requirements | [ ] 3T MRI |  | [ ] Arthrogram | [ ]  Prostate imaging |  |
| Is Gadolinium required? | [ ] Yes | [ ] No |

MHRA guidelines recommend all patients (particularly those over 65) should be screened for renal dysfunction by obtaining a history, laboratory testing or both

Relevant previous imaging [ ]  None / [ ]  Film / [ ]  Digital **Date:**

##  SAFETY CHECK as recommended by the MHRA, the referring clinician is required to assess patient safety for MRI scans

|  |  |  |  |
| --- | --- | --- | --- |
| Does the patient have a cardiac pacemaker or valve? | [ ] Yes | [ ] No | If ‘yes’ – unable to proceed with scan |
| Does the patient have an intracranial aneurysm clip or a programmable ventriculoperitoneal shunt? | [ ] Yes | [ ] No | If ‘yes’ – unable to proceed with scan |
| Has the patient had a cochlear implant or neurotransmitter? | [ ] Yes | [ ] No | If ‘yes’ – unable to proceed with scan |
| Does the patient have renal impairment? | [ ] Yes | [ ] No | If ‘yes’ – an extrapolated GFR should be determined from the serum creatinine and discussed with LCAD |
| Has the patient had surgery in the last 6 weeks? | [ ] Yes | [ ] No | If ‘yes’ – unable to proceed with scan |
| Is there a history of metallic foreign bodies in the patient’s eye? | [ ] Yes | [ ] No | If ‘yes’ – it is mandatory to exclude metallic orbital foreign bodies by orbital X-ray. If no metallic foreign body is detected, scan can proceed. If detected, unable to proceed |
| Is the patient breastfeeding? | [ ] Yes | [x] No | If ‘yes’- intravenous contrast cannot be administered while breastfeeding and the patient should contact LCAD for instructions |
| Is the patient pregnant? | [ ] Yes | [ ] No | If yes please note that we cannot proceed with scan |
| Is the patient involved in paid professional sports?  | [ ] Yes | [ ] No |  |

 REFERRING CLINICIAN’S DETAILS

Mr Mrs Miss Dr Other (please specify):

[ ] No

[ ] Yes

Do you want the report sent to another clinician?

If yes please give full details:

Please confirm how you would like to receive the report by ticking below:

[ ] **Email** [ ] **Post**

Referrer name:

Specialty/profession:

Registration code:

Hospital/practice:

Email:

Address:

Signature: Date:

Post code:

Tel:

Fax:

If requesting an MRI referral for the above patient I have understood the contraindications for MRI scans and, where requested, the implications and side effects associated with the administration of intravenous Gadolinium.

**When completed - please email** **this form to booking@vistahealth.co.uk**  **| T 0333 200 2064 |** [**www.vistahealth.co.uk**](http://www.vistahealth.co.uk)