

Imaging Request Form

Ultrasound, X-ray

MRI, CT, DEXA



136 Harley Street, London W1G 7JZ

Bookings hotline phone: 020 7317 2790 fax: 020 7436 7059

Patient details

Name: _____

Date of Birth: _____

Address: _____

Postcode: _____

Tel: _____ Mobile: _____

Email: _____

Male Female

Start date of last Menstrual Period (if applicable) _____

Patient arrival: Trolley Wheelchair Walking

Funding: NHS Self Funded Private Patient

Patient's insurance company: _____

Membership number: _____

Pre-authorisation number (if known): _____

Please note: Uninsured patients and patients without pre-authorisation are required to pay on the day of their appointment.

Referral information

Ultrasound X-ray MRI CT DEXA

Area to be imaged:

Creatinine level: _____

Date of test: _____

Reason for referral:

Relevant previous medical history

Details (including any surgery and current medication):

Please include copies of any recent X-rays or scan reports

Safety check

Could the patient be pregnant? Yes No

Is the patient breast feeding? Yes No

Is the patient a high infection risk? Yes No

If yes, please specify: _____

Is the patient diabetic? Yes No

Is the diabetes controlled by: Diet Insulin Tablet

Is the patient on Metformin? Yes No

Does the patient have any allergies? Yes No

If yes, please specify: _____

To be completed for all MRI examinations

MRI Contraindications - does the patient have:

A pacemaker? Yes No

A cerebral aneurysm clip? Yes No

Cochlear implants? Yes No

Neurostimulators? Yes No

Programmable hydrocephalus shunt? Yes No

Metallic foreign body in eye? Yes No

Other metallic implants? Yes No

Referring Clinician's details

IR(ME)R 2000 regulations require this form to be signed by the referring Clinician

Consultant name: _____

Signature: _____ Date: _____

Address: _____

Tel: _____

Fax: _____

Email: _____

For general enquiries phone: 020 7317 2790 email: 136@alliance.co.uk