

**HIGHLY CONFIDENTIAL**

Please complete all sections of this request form and send it to:

NHS No.	UBR No.
Surname:	
First Name:	Middle Initial:
Male/Female:	Date of Birth:
Address:	
	Post Code:
Tel No (home):	(mobile):

# MRI

Send referrals by secure post to your RBMS Office

Referring Clinician Name: \_\_\_\_\_  
Referring Clinician Address: \_\_\_\_\_  
NHS Mail Address: \_\_\_\_\_

GP Name: \_\_\_\_\_  
GP Address: \_\_\_\_\_  
NHS Mail Address: \_\_\_\_\_

### Medical Information – Does the patient have?

A cardiac pacemaker?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Any surgery on heart, head or spine?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Other metallic implants?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Neurostimulator?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Programmable hydrocephalus shunt?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Metallic foreign body in eye (ever)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cochlear implant	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Other surgery in the last 3 months?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Could the patient be pregnant?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is the patient breast feeding?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does the patient have any allergies?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is the patient an infection risk (e.g. MRSA)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is the patient diabetic? <i>(if yes please give details of treatment below)</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

If foreign body in eye, state date of x-ray Date: \_\_\_\_\_

Interpreter required? *(If yes specify language):* \_\_\_\_\_

Any special needs e.g. hearing, mobility, speech or other? *(If yes please specify):* \_\_\_\_\_

Examination requested:

Please state date, location and type of relevant previous investigations:

Clinical history/indications for the examination and clinical question to be answered:

Referrer's declaration:

I have discussed the examination with the patient and considered the contraindications as detailed above.

Referring Clinician *(Print):* \_\_\_\_\_

Referring Clinician *(Signature):* \_\_\_\_\_

Date: \_\_\_\_\_

GMC no. / GP no. or equivalent \_\_\_\_\_

Office Use only

Operator's Signature: \_\_\_\_\_