# MRI Imaging Request Form
# Guildford Diagnostic Imaging

Alliance Medical

Patient Name: ____________________ Title: __________

Date of Birth: ____________________ Male ☐ Female ☐

Patient Address: ____________________

____________________

____________________

____________________ Postcode: __________

Telephone Numbers

Home: ____________________ Work: __________

In-Patient: ☐ Ward: __________ Name of Hospital: __________

Hospital Number: __________ Tel. Number: __________

Who is responsible for the patient's account? Patient ☐ Other ☐

Clinical Details: ____________________

____________________

____________________

Provisional Diagnosis: ____________________

____________________

Part(s) to be imaged: ____________________

Priority: Urgent ☐ Routine ☐

## Important

MRI Examinations cannot be carried out on patients with: cardiac pacemakers, cerebral aneurysm clips, cochlear implants, intra-ocular metallic fragments. Please note table weight limit of 25 stone (158 kgs) and maximum patient girth of 50 ins (127cms).

Signature: ____________________ Date: __________

Name of Referring Consultant: ____________________ Tel. Number: __________

Address for Report: ____________________

____________________

____________________ Postcode: __________

Appointment booked for: ____________________

Appointment confirmed ☐ No contraindications ☐

Guildford Diagnostic Imaging will contact the patient direct either by letter or telephone to make an appointment.

Please send or fax this form to:

Guildford Diagnostic Imaging
Egerton Road, Guildford, Surrey GU2 7XU
Tel: 01483 303106 Fax: 01483 304656 Email: gmri@alliance.co.uk