

Imaging Request Form

Sidcup MRI



Patient Name: _____	Title: _____
Date of Birth: _____	Male <input type="checkbox"/> Female <input type="checkbox"/>
Patient Address: _____	

Postcode: _____	
Telephone Numbers	
Home: _____	Work: _____

In-Patient: <input type="checkbox"/>	Ward: _____	Name of Hospital: _____
Hospital Number: _____	Tel. Number: _____	
Who is responsible for the patient's account?		Patient <input type="checkbox"/> Other <input type="checkbox"/>
Clinical Details: _____		

Provisional Diagnosis: _____		

Part(s) to be imaged: _____		
Priority: Urgent <input type="checkbox"/> Routine <input type="checkbox"/>		

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 <input type="checkbox"/>	No contraindications <input type="checkbox"/>

Sidcup MRI will contact the patient direct either by letter or telephone to make an appointment.

Please send or fax this form to:

Sidcup MRI

Queen Mary's Hospital, Frogna Avenue, Sidcup, Kent DA14 6LT

Tel: 020 8309 4720 Fax: 020 8309 4721 Email: sidcupmri@alliance.co.uk