Imaging Request Form - 136 Harley Street
Ultrasound, X-Ray, Fluoroscopy, MRI, CT

Harley Street Centres

136 Harley Street, London W1G 7JZ
10-11 Bulstrode Place, London W1U 2HX

Bookings: tel: **+44 (0)20 7317 2790** fax: **+44 (0)20 7935 4308** email: **136@alliance.co.uk**

Patient details

Name: ______________________

Date of Birth: ______________________

Address: ______________________

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______________________ 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 requested to pay on the day of their appointment.

Referral information

☐ MRI ☐ CT ☐ X-Ray ☐ Ultrasound ☐ Fluoroscopy

Area under examination:

e-GFR value: ______________________

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 taking 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 ☐

X-Ray Exposure Factors:

Referring Clinician's details

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

Consultant name: ______________________

Signature: ______________________ Date: ______________________

Address: ______________________

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Tel: ______________________

Fax: ______________________

Email: ______________________

For general enquiries tel: **+44 (0)20 7317 2790** email: **136@alliance.co.uk** web: **www.alliancemedicallondon.co.uk**