

Imaging Request Form

Wythenshawe Cardiac MRI



Patient Details

NHS No: _____ RM2: _____

Surname: _____

Forename: _____

Address: _____

_____ Postcode : _____

D.O.B: _____ Sex: _____

Tel No: _____

Hospital Information

Ward/Dept/Hospital: _____

Clinic return date: _____

Referring Consultant: _____

Previous Coronary Angiogram/ECHO/SPECT Date Nr/Findings:

MRI Contra-indications - does the patient have:

A cardiac pacemaker?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Is the patient diabetic?	Yes <input type="checkbox"/> No <input type="checkbox"/>
A history of neurosurgery?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Is there a cross-infection risk? (eg MRSA)	Yes <input type="checkbox"/> No <input type="checkbox"/>
A neurostimulator?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Can the patient breath-hold?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Programmable hydrocephalus shunt?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Does the patient have renal impairment?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Metallic foreign body in the eye (ever)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Creatinine level: _____ Date: _____	
A cochlear implant?	Yes <input type="checkbox"/> No <input type="checkbox"/>	eGFR: _____ Date: _____	
Surgery within the last 3 months?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Interpreter required? If yes, specific language: _____	
Could the patient be pregnant?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Any other special requirements (eg mobility): _____	
Does the patient have any STENTS or REPLACEMENT HEART VALVES?		Yes <input type="checkbox"/> No <input type="checkbox"/>	

If yes please provide details of make/model: _____

Examination Details

Examination requested: _____

Clinical history and indication for the examination: _____

Question to be answered: _____

Referring Practitioner's Details

Referrers Name: _____ Referrers Signature: _____

Title/Grade: _____ Pager/Bleep/Telephone: _____ Date: _____

For CMR Use: Supervised: Unsupervised: Urgent:

Exam Code: _____ Routine:

Signed: _____ Suspend:

PRISM **DMS**

Date: _____ Time: _____

Short Notice: Confirmed:

Please send or fax this form to:

Cardiac MRI Centre, North West Heart Centre, Wythenshawe Hospital,
UHSM NHS Foundation Trust, Southmoor Road, Manchester M23 9LT.

Tel: 0161 291 4560 Fax: 0161 291 4561