

Patient Details

Name: _____

Date of Birth: _____

Address: _____

Postcode: _____

Telephone: _____ Mobile: _____

Email: _____

Male Female

Ethnic Group

White Mixed Asian

Black Chinese Other

Patient Source GP Private

Clinical Details

Please give brief patient history & provisional diagnosis:

Please ensure that your patient does not have any metal splinters in their eyes, cardiac pacemaker, cerebral aneurysm clips, metal implants, or any other condition which contra-indicates MRI.

Area to be imaged

Brain Cervical Spine Hip l/r

IAMs Thoracic Spine Knee l/r

Pituitary Lumbar Spine Ankle l/r

Orbits Pelvis Shoulder l/r

Angiogram

Other (please specify) _____

Referring Clinician details

Clinician's name: _____

Practice name: _____

Practice code: _____

Referring Clinician's signature:

Date: _____

Safety

Weight (max 127kg): _____

Serum Creatine Level: _____

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For General enquiries:

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