MRI REQUEST

Bupa CROMWELL HOSPITAL

PLEASE BRING THIS FORM WITH YOU WHEN YOU ATTEND THE HOSPITAL
All sections of this form must be fully completed

Appointment details
Scan date:
Scan time:
Referring clinician:
Report/CD to:
Follow-up appointment:

Patient details – (Place sticker here if available)
First name:
Last name:
Date of birth:
☐ Male ☐ Female
Hospital no:

Contraindications – To be filled by referring clinician		
Does the patient have any of the following?		
A pacemaker/ICD:	☐ Yes	☐ No
A cochlear implant:	☐ Yes	☐ No
Metallic fragments in eye(s):	☐ Yes	☐ No
Pregnant (if applicable):	☐ Yes	☐ No
If pregnant, is it within the 1st trimester:	☐ Yes	☐ No

Billing details – Place the stamp here
Charge code:

If 'YES' to any of the above please contact MRI Department on 020 7460 5612

Examination details		
Scan required:		
Contrast required:	☐ Yes	☐ No
If "Yes":		
Any known problems with kidney function:	☐ Yes	☐ No
Any known allergy to gadolinium contrast:	☐ Yes	☐ No
For patients below 16 years or above 65 years of age:		
Serum creatinine/eGFR:		
Date measured:		

Contrast details – If used, to be filled by the MRI radiographer
Contrast injected:
Volume injected:
Batch no:
Expiry date:
Injected by:
Any complications:

CLINICAL INDICATION/HISTORY AND REASON FOR EXAM
What clinical question do you require answering?

Scans under GA : Please contact the MRI Department directly to enquire for the scans that need GA

Scan Details	**Referring Clinician's Details**
Authorised by ..... Date	
Operator..... ..... Date	Signature ..... Date .....

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MRI department contact details: MRI telephone: 020 7460 5611 or 020 7460 5612. MRI fax: 020 7835 2492

Guidance notes for referrers

In accordance with the Ionising Radiation (Medical Exposures) Regulation 2000, the Bupa Cromwell Hospital Radiology Department would like to make all Referrers aware of the following Guidelines:

Referrals:

- A request for a Radiological Examination will be regarded as a request from one Clinician or Health Professional to the Radiology Department for an opinion based upon a radiological examination to assist in the management of a clinical problem.
- Diagnostic Imaging or radiological procedures will only be performed upon a written request signed by a Registered Medical or Dental Practitioner or by an authorised Non-Medical Practitioner.
- Signed referrals (request form or letter) must precede or accompany the patient. Signed faxes are also accepted.
- All requests must carry sufficient information to identify the patient. This normally consists of first name, middle name if any, and family name, date of birth and address.
- All requests must carry sufficient clinical information to enable the requested examination to be justified. Referral criteria are based on the Royal College of Radiologists' Guidelines - "Making the best use of a Department of Clinical Radiology: Guidelines for Doctors".
- All requests shall clearly state the examination requested.
- All requests must include contact details of the Referring Clinician including address and telephone number.

Females of childbearing age (12 - 55 years):

- All requests for MRI examinations for females of childbearing age (12 – 55 years) must state the date of the first day of the patient's menstrual period.

Clinical justification of requests:

- All requests for imaging will be assessed prior to exposure by the appropriate Practitioner for the examination to ensure that they meet with The Royal College of Radiologists' Guidelines and any local Guidelines and that, in their professional judgement, they are clinically justified *(Royal College of Radiologists Publication: BCFR(00)S).*

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