Yorkshire Clinic GP Direct access Imaging Request Form - MRI

Ramsay Health Care
People caring for people

Patient Details:

Patient NHS Number: ______________________ Patient Type: ______________

Forename: ______________________ Surname: ______________________

Date of Birth: __________ Sex: __________ Any Mobility issues?

Address: ______________________________ Interpreter Required?

______________________________ If Yes, state language: __________

____

Postcode: __________ Telephone Number: __________ Height: _____ Weight: _____

MRI Contraindications: This section must be completed by the referring clinician.

	Yes	No		Yes	No
Cardiac pacemaker?			Diabetic?		
Previous neurosurgery?			Cross infection risk?		
Hydrocephalus shunt?			Any renal impairment?		
Cochlear implant?			Creatinine level/eGFR: __________ Date: ________		
Metallic foreign body in the eye?			(only if already known and tested within 3 months)		
Implantable drug infusion pump?					
Any possibility of pregnancy			LMP: ______________		

Comments:

Examination Requested: ______________________ **Laterality (If required):** __________

Clinical History and question to be answered:

Referring Practitioners Details:

Title: ______________________

Referrers Name: ______________________ GMC Number: ______________________

Address: ____

____

Post Code: ______________________ GP Signature:

Telephone: ______________________

Date: ______________________ ***Document cannot be altered after signature is applied within adobe***

Protocol/ Radiographer instructions: *****For Yorkshire Clinic Use Only***** **Radiographer/Radiologist Signature Only**