MRI Referral Form

HSU Clinical & Rehabilitation Services

Please note that we are unable to accept referrals for contrast enhanced MRI scans All scans must be paid for before departure

Patient Details

Mr, Mrs, Miss, Dr, Other (please specify):	First Name:	Surname:
Date of birth:	Male O Female O	Tel: Home Mobile
Address Email:		
Does the patient have any special requirements e.g. require an interpreter, oxygen or a wheel chair? *Please proved details*		

Relevant clinical detail	
Please proved as much relevant clinical information as possible	Patient weight: Patient height: Claustrophobic? Yes/No (Please circle)

Investigation(s) Required

Tick investigation required; please indicate which side of the body where appropriate. **(please note that investigations in BOLD will incur additional costs)**

Knee	L O	R O	Lumbar spine O	**Lumbar spine AND Lumbar spine weight bearing Yes O**	Shoulder	L O	R O	Brain O
Ankle	L O	R O		**Lumbar spine AND Lumbar spine in flexion and extension Yes O**	Wrist	L O	R O	
Foot	L O	R O	Cervical Spine O	**Cervical spine AND Cervical spine in flexion and extension Yes O**	Hand	L O	R O	
Sacroiliac joints O			Thoracic spine O	**Thoracic spine AND Thoracic spine weight bearing Yes O**	Elbow	L O	R O	

Safety check as recommended by the MHRA, the referring clinician is required to assess the patient safety for MRI scans

Does the patient have any implanted metallic devices? (e.g. cardiac pacemaker, artificial heart valve, cerebral aneurysm clips, Neurotransmitter, cochlear implant etc.)	Yes O	No O
Is the patient know to have metallic fragments in their eyes? *If yes, it is mandatory to exclude metal foreign bodies in the eyes by orbital X-ray. If a metallic foreign body is detected, unable to proceed with MRI.*	Yes O	No O

Referring Clinician's details

Mr, Mrs, Miss, Dr, Other please specify): Referrer name:	If NHS funded please provide PO Number/Invoice information
Speciality/Profession:	Regulatory Body Registration Number (e.g. GMC. GCC, HCPC etc.)
Hospital/Practice Name: Address Tel: Fax: Email:	**Report and images will be sent directly to the referrer via IEP Anyone** To facilitate this please provide: 1. Email address: 2. Mobile number or Additional email address:
Emergency contact number:	**Signature** **Date**

Please post or fax this form to: Bournemouth Open Upright MRI, Parkwood Campus, Parkwood Road, Bournemouth BH5 2DF Fax 01202 418793
Secure email via Egress: Mrireferrals@aecc.ac.uk - For any further information please telephone 01202 436276