Imaging Request Form

MEDICAL IMAGING PARTNERSHIP

Patient Name/Label: _____

Address: _____

Postcode: _____ ID/NHS: _____

Date of Birth: _____

Home Number: _____

Work/Mobile Number: _____

EXAMINATION REQUESTED

If available:

X-Ray ☐

Ultrasound ☐

MRI ☐
(please see declaration for contra indications)

If contrast is required please provide the following infomation:

Creatinine level: _____

Date of test: _____

BODY PART TO BE IMAGED

CLINICAL DETAILS

Including any surgery and current medication:

REFERRER'S DECLARATION.

1. The correct patient details have been entered.
2. To the best of my knowledge this patient does not have any absolute contra-indications to MRI (e.g. cardiac pacemaker, pacing wire, aneurysm clips, cochlear implant, IOFB).
3. I have given sufficient clinical information for the request to be justified according to IR(ME)R 2000.
4. I have taken into account the possibility of pregnancy. **Ignore LMP ruling** ☐
5. I will ensure that the examination result is recorded in the patient's case notes.

Referrer's Signature: _____

Print Name: _____

Date: _____

Referrer's speciality: _____

Referrer's Telephone Number: _____

Address for report: _____

I hereby give consent to the above examination and confirm that the examination/procedure has been explained to me.

Patient's Signature: *If applicable, I confirm to the best of my knowledge that I am not pregnant.*	Operator's Signature:
Date:	Date:

FOR IMAGING DEPARTMENT USE ONLY

Justification: This procedure has been justified under the terms of the IR(ME)R 2000 Regulations

RADIOLOGIST'S OR RADIOGRAPHER'S SIGNATURE:		
BILLING INFORMATION (PLEASE TICK):		
☐NHS	☐Insured	☐Self Funding

EXPOSURE FACTORS	
MAS:	
KVP:	
DOSE:	
NUMBER OF IMAGES:	

Please send this completed form to Medical Imaging Partnership, Unit 7, The Pavillions, Brighton Road, Pease Pottage, W. Sussex, RH11 9BJ. Ph/fx 01293 534043