

# Imaging Request Form

## MRI, CT, X-Ray, Fluoroscopy, Ultrasound



Harley Street Centres

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**Bookings:** tel: **0845 456 8878** fax: **+44 (0)20 7935 7715** email: **london@alliance.co.uk**

### Patient details

Name: _____	Male <input type="checkbox"/> Female <input type="checkbox"/>
Date of Birth: _____	Start date of last Menstrual Period (if applicable) _____
Address: _____	Patient arrival: Trolley <input type="checkbox"/> Wheelchair <input type="checkbox"/> Walking <input type="checkbox"/>
_____	Funding: NHS <input type="checkbox"/> Self Funded <input type="checkbox"/> Private Patient <input type="checkbox"/>
_____ Postcode: _____	Patient's insurance company: _____
Tel: _____ Mobile: _____	Membership number: _____
Email: _____	Pre-authorisation number (if known): _____

**Please note:** Uninsured patients and patients without pre-authorisation are requested to pay on the day of their appointment.

### Referral information

MRI  CT  X-Ray  Ultrasound  Fluoroscopy

Area under examination: \_\_\_\_\_

e-GFR value: \_\_\_\_\_

Date of test: \_\_\_\_\_

Reason for referral: \_\_\_\_\_

### Relevant previous medical history

Details (including any surgery and current medication):

Please include copies of any recent X-Rays or scan reports

### Safety check

Could the patient be pregnant? Yes  No

Is the patient breast feeding? Yes  No

Is the patient a high infection risk? Yes  No

If yes, please specify: \_\_\_\_\_

Is the patient diabetic? Yes  No

Is the diabetes controlled by: Diet  Insulin  Tablet

Is the patient taking Metformin? Yes  No

Does the patient have any allergies? Yes  No

If yes, please specify: \_\_\_\_\_

### To be completed for all MRI examinations

**MRI Contraindications** - does the patient have:

A pacemaker? Yes  No

A cerebral aneurysm clip? Yes  No

Cochlear implants? Yes  No

Neurostimulators? Yes  No

Programmable hydrocephalus shunt? Yes  No

Metallic foreign body in eye? Yes  No

Other metallic implants? Yes  No

### Referring Clinician's details

IR(ME)R 2000 regulations require this form to be signed by the referring clinician

Consultant name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Tel: \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

**For general enquiries** tel: **+44 (0)20 7935 7711** email: **london@alliance.co.uk** web: **www.alliancemedicallondon.co.uk**