# Imaging Request Form
# MRI, CT, X-ray, Ultrasound

Alliance Medical

10-11 Bulstrode Place
London W1U 2HX

18 - 22 Queen Anne Street
London W1G 8HU

**Bookings hotline** tel: **0845 456 8878** fax: **020 7935 7715**

## Patient details

Name: _____

Date of Birth: _____

Address: _____

_____

_____ Postcode: _____

Tel: _____ Mobile: _____

Email: _____

Male ☐ Female ☐

Start date of last Menstrual Period (if applicable) _____

Patient arrival: Trolley ☐ Wheelchair ☐ Walking ☐

Funding: NHS ☐ Self Funded ☐ Private Patient ☐

Patient's insurance company: _____

Membership number: _____

Pre-authorisation number (if known): _____

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

## Referral information

☐ MRI ☐ CT ☐ X-ray ☐ Ultrasound

Area to be imaged:

Creatinine level: _____

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 on 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: _____