

Imaging Request Form

MRI, CT, X-ray, Ultrasound



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-authorization number (if known): _____
Please note: Uninsured patients and patients without pre-authorization 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: _____

For general enquiries tel: **020 7935 7711** email: **london@alliance.co.uk**