MRI referral form

Patient details

Mr Mrs Miss Dr Other (please specify)

First name

Surname

Date of birth | Male / Female

Tel home | Mobile

Email

Address

Postcode

Please tell us if you would like your patient to be seen at an alternative location to Vista Waterloo. (Self-Pay MRI only) Please circle preferred site below:

Golders Green | Ealing | Stratford | Hornchurch

We cannot guarantee location but will do our best!

Self pay / Insured

Insurers name

Policy number

Relevant clinical details

Region(s) to be scanned

Urgent scan? Yes / No

Additional requirements: **3T MRI** **Arthrogram** **Prostate imaging**

Is Gadolinium required? **Yes** / No

MHRA guidelines recommend all patients (particularly those over 65) should be screened for renal dysfunction by obtaining a history, laboratory testing or both

Relevant previous imaging None / Film / Digital **Date:**

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

Question	Y / N	Action
Does the patient have a cardiac pacemaker?	Y / N	If 'yes' – unable to proceed with scan
Does the patient have an intracranial aneurysm clip or a programmable ventriculoperitoneal shunt?	Y / N	If 'yes' – unable to proceed with scan
Has the patient had a cochlear implant or neurotransmitter?	Y / N	If 'yes' – unable to proceed with scan
Does the patient have renal impairment?	Y / N	If 'yes' – an extrapolated GFR should be determined from the serum creatinine and discussed with Vista
Has the patient had surgery in the last 8 weeks?	Y / N	If 'yes' – unable to proceed with scan
Is there a history of metallic foreign bodies in the patients eye?	Y / N	If 'yes' – it is mandatory to exclude metallic orbital foreign bodies by orbital X-ray. If no metallic foreign body is detected, scan can proceed. If detected, unable to proceed
Is the patient breastfeeding?	Y / N	If 'yes'- intravenous contrast cannot be administered while breastfeeding and the patient should contact Vista for instructions
Is the patient pregnant?	Y / N	If ≤ 4 months – no scan; if ≥ 4 months the referring clinician should contact Vista

Referring clinician's details

Mr Mrs Miss Dr Other (please specify)

Referrer name

Specialty / profession

Hospital / practice

Address

Postcode

Email

Tel | Fax

Emergency contact no.

Please confirm how you would like to receive the report by circling below:

By Email | By Post | By Fax

Do you want the report sent to another clinician?

If yes please give full details:

Signature | Date

In signing and requesting the MRI referral for the above patient I have understood the contraindications for MRI scans and, where requested, the implications and side effects associated with the administration of intravenous Gadolinium.

When completed please email this form to help@vistadiagnostics.co.uk or fax it to 0845 4502171

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