vista diagnostics
Affordable & Accessible MRI

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

GP
Practice
Address

Tel
Self pay ◯ Insured ◯
Insurers name
Policy number

Relevant clinical details

Region(s) to be scanned

Urgent ◯ Non-urgent ◯ If urgent, date of scan required

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 ◯

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

Does the patient have a cardiac pacemaker?	Yes ◯	No ◯	If 'yes' – unable to proceed with scan
Does the patient have an intracranial aneurysm clip or a programmable ventriculoperitoneal shunt?	Yes ◯	No ◯	If 'yes' – unable to proceed with scan
Has the patient had a cochlear implant or neurotransmitter?	Yes ◯	No ◯	If 'yes' – unable to proceed with scan
Does the patient have renal impairment?	Yes ◯	No ◯	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?	Yes ◯	No ◯	If 'yes' – unable to proceed with scan
Is there a history of metallic foreign bodies in the patients eye?	Yes ◯	No ◯	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?	Yes ◯	No ◯	If 'yes' – intravenous contrast cannot be administered while breastfeeding and the patient should contact Vista for instructions.
Is the patient pregnant?	Yes ◯	No ◯	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.

How would you like to receive the report? Email ◯ Post ◯ Fax ◯

And the images? CD ◯ Film ◯

Do you want the report sent to another clinician? Yes ◯ No ◯
If yes give 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.

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