



MRI referral form

Patient details

Mr Mrs Miss Dr Other (please specify)	Alternative locations to Vista London Waterloo: Please circle preferred site below if your patient prefers their scan to take place at another location (appointment availability may vary): Golders Green Ealing Stratford Hornchurch	
First name		
Surname		
Date of birth		Male / Female
Tel home		Mobile
Email		
Address		
Postcode		
		Self-pay / Insured
	Insurers name	
	Policy number	

Relevant clinical details

Region(s) to be scanned

	Additional requirements: 3T MRI Arthrogram Prostate imaging
	Is Gadolinium required? Yes / No
	<small>MHRA guidelines recommend all patients (particularly those over 65) should be screened for renal dysfunction by obtaining a history, laboratory testing or both</small>
Urgent scan? Yes / No	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

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)	Please confirm how you would like to receive the report by circling below: Email Post FAX Do you want the report sent to another clinician? If yes please give full details: Signature Date
Referrer name	
Specialty / profession	
Hospital / practice	
Address	
Postcode	
Email	
Tel Fax	
Emergency contact no.	

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 booking@vistadiagnostics.co.uk or fax it to 0333 200 2065

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