UME GROUP DIAGNOSTICS

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MRI Referral Form

Cardiff Fax 0844 567 8137 *Coventry Fax 02476 604 526* *Harley Street Fax 0844 567 8218*
Hendon Fax 0844 567 4568 *Swindon Fax 01793 812 254*

Patient details (affix label if available)

Title Other	Address
First name	
Surname	Postcode
DOB Male ◯ Female ◯	Self pay ◯ Insured ◯ NHS ◯ Third party ◯
Contact telephone number(s):	Insurance Co
Mobility: Mobile ◯ Non-mobile ◯	Policy number

Examination/Procedure

Open MRI ◯ Extremity MRI ◯ 3T MRI ◯ 1.5T MRI ◯

	Routine ◯ Urgent ◯
	Date of follow up appointment:

Relevant clinical details

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

Cardiac pacemakers, artificial heart valves, cochlear implants, cerebral aneurysm clips are contra-indicated for MRI

Does the patient have a metal implant or pacemaker? ◯ Yes ◯ No

Has the patient ever had an injury to the eye involving a metallic object? ◯ Yes ◯ No

Referring clinician's details (stamp or affix label if available)

Referrer name:

GMC number:

Contact Tel No:

Signature of Referring clinician :

Please indicate how you would like to receive the results of the investigation?

◯ **By Post** - Postal Address:

◯ **By Fax** - Fax Number:

◯ **By Email** - Email Address:

CD of images will be given to the patient. Do you wish to receive a copy? ◯ Yes ◯ No

Further copies of this form are available to download at www.umediagnostics.com

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