



# Expert Eye

Tel: 0845 130 2918 Fax: 0845 130 2921

## MRI REQUEST FORM

### Requestor details:

Name: .....

Address: .....

.....

..... Postcode: .....

Contact Tel: .....

Signed: .....

Date: .....

Surname:

First Name(s):

Date of Birth:

Postal Address:

Tel: (H)

(W)

(Mob)

Invoice to be sent to:

Details must be filled in before request accepted.

MRI report will be sent to the requestor above. If a copy report is required please give details below:

Name: .....

Address: .....

.....

..... Postcode: .....

### Clinical Details:

### MRI Investigation Requested (please tick):

- Brain  IAMs
- Cervical Spine  Thoracic Spine  Lumbar Spine
- Chest  Abdomen  Pelvis
- Knee R  L
- Shoulder R  L
- Other Joint (please specify) ..... R  L
- Other region (please specify) .....

### Does your patient have :

- A Cardiac pacemaker?  Yes  No
- Cerebral aneurysm clips?  Yes  No
- Metallic Heart Valve?  Yes  No
- Hx intraocular foreign body?  Yes  No
- Neuro Stimulator?  Yes  No
- Any metal in Body?  Yes  No  
(if Yes give details) .....
- Cardiac Surgery?  Yes  No
- Pregnant?  Yes  No

### FOR INTERNAL USE ONLY:

PROTOCOL:

Signed: \_\_\_\_\_ Consultant Radiologist

Date: \_\_\_\_\_

CONTRAST AGENT	Dose mls	Sig

EE ID No:

Appointment Date:

Appointment Time: