



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: