MEDICAL IMAGING
PARTNERSHIP

Imaging Request Form

Patient Name/Label: **Address:** **Postcode:** **ID/NHS:**	**Date of Birth:** **Home Number:** **Work/Mobile No.**

Examination Requested *if available* [ ] X-Ray [ ] Ultrasound [ ] MRI *(please see declaration for contra indications)* **If contrast is required please provide the following information:** *Creatinine Level:* *Date of Test:* [ ] CT (Available off site by discussion)	**Body part to be imaged** **Clinical Details** *Including surgery and any medication:*

Referrer's Declaration.

1) The correct patient details have been entered.

2) To the best of my knowledge this patient does not have any absolute contra-indications to MRI (e.g. cardiac pacemaker, pacing wire, aneurysm clips, cochlear implant, IOFB).

3) I have given sufficient clinical information for the request to be justified according to IR(ME)R 2000.

4) I have taken into account the possibility of pregnancy.
[ ] **Ignore LMP Ruling**

5) I will ensure that the examination result is recorded in the patient's case notes.

Referrer's Signature:

Print Name:

Date:

If applicable, I confirm to the best of my knowledge that I am not pregnant.

Patient's Signature:

I hereby give consent to the above examination and confirm that the examination/procedure has been explained to me.

Patient's Signature: *Date:*	*Operator's Signature:* *Date:*

For Imaging Department Use Only Justification: This procedure has been justified under the terms of the IR(ME)R 2000 Regulations	**Exposure Factors**	
Radiologist's or radiographer's signature:	mAs:	
	kVp:	
Billing Information (please tick): [ ] NHS [ ] Insured [ ] Self Funding	Dose:	
	Number of Images:	