Request for Magnetic Resonance Examination

SWIS
South West
Imaging Services Ltd

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Patient Details:

Surname:

First Name:

Date of Birth: Age:

Address:

Post Code:

Contact Number:

GP Name / Practice:

Referrer Details:

Name:

Signature:

Occupation:

Address for Report:

Post Code:

Tel:

Fax:

Email:

Clinical Details / Reasons for Referral:	**Area to be Examined**

Declaration: The presence of a cardiac pacemaker or a cochlear implant are absolute contraindications to MRI scanning. Please sign below to confirm that your patient does not have one of these:

Initials: ______________________________

Please Note: The presence of metal fragments in the eye, Intracranial vessel clips or an implanted nerve stimulator may also preclude MRI scanning. Please inform us of any of the above in advance of us contacting the patient.

Previous Scans: Yes / No Year:

Where:

Do you require a specialist assessment at the time of your scan? Yes / No

If yes, please indicate the specialist you would like to see your patient? (A list of participating specialists is available on the web site or by phone.)

Name: ______________________________

Specialty: ______________________________

For Office use:

Appointment Details: Date: Time: Date Patient Contacted:

Safety Questionnaire Completed: Y / N Date: Clinic:

Total Cost: £ Payment Method: Credit card Debit card Cheque Cash

Date Paid: Date Receipt sent:

Scan Protocol: Radiologist Signature:

Examination Procedure: Contrast: Y / N Dose: Given by:

One Stop: Y / N Consultant:

SWIS Ref No.: