MRI request

Cromwell Hospital

MRI department contact details: For bookings – mri@cromwellhospital.com 020 7460 5611 **For clinical enquiries only** - 020 7460 5612

PLEASE BRING THIS FORM WITH YOU WHEN YOU ATTEND THE HOSPITAL
ALTERNATIVELY, EMAIL IT TO mri@cromwellhospital.com
All sections of this form must be fully completed

Appointment details	
Scan date:	Scan time:
Report/CD to:	
Referrer's email:	
Follow-up appointment:	

Patient details – (Place sticker here if available)	
First name:	
Last name:	
Date of birth:	Sex:
Hospital no:	

PLEASE CONTACT MRI DEPARTMENT AT mri@cromwellhospital.com IF 'YES' TO ANY OF THE QUESTIONS

Contraindications – To be filled by referring clinician		
Does the patient have any of the following?		
A pacemaker/ICD:	☐ Yes	☐ No
Cochlear Implant/Aneurysm Clip:	☐ Yes	☐ No
Metallic fragments in eye(s):	☐ Yes	☐ No
VP Shunt/ Neurostimulator	☐ Yes	☐ No
Pregnant (if applicable):	☐ Yes	☐ No
If pregnant, is it within the 1st trimester:	☐ Yes	☐ No

Implant Details (scan to proceed only if MRI conditional) To be filled by referring clinician
Device
Manufacturer
Model
Date of implantation
Charge code

PLEASE NOTE THAT WE DO NOT OFFER MRI SCANS FOR MRI NON-CONDITIONAL DEVICES

Scan Required

(Please provide a brief and clear clinical indication for the scan required)

Scans under GA : Please contact the MRI Department directly to enquire for the scans that need GA
For booking paediatric scans with GA, please contact the paediatric department directly on 02074605991

Contrast Required ☐ Yes ☐ No

If Yes, is there:
Any problems with kidney function? ☐ Yes ☐ No
Known allergy to gadolinium contrast? ☐ Yes ☐ No

For patients below 16 years or above 65 years of age
Serum Creatinine/ eGFR .....
Date measured .....

Contrast Details

I.V Injection	Volume Injected	Batch Number	Expiry Date	Injected/ Checked By
Gadovist				
Primovist				
Saline Flush				
Saline Chase				

All relevant sections of this form must be fully completed for it to be accepted

For MRI Department's use only	Referring Clinician's Details
Authorised by ..... Date	**Name .....**
Radiographer ..... Date	**Date ..... Signature**