# 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 | | Patient details – (Place sticker here if available) | |
|---|---|---|---|
| Scan date: | Scan time: | First name: | |
| Report/CD to: | | Last name: | |
| Referrer's email: | | Date of birth: | Sex: |
| Follow-up appointment: | | Hospital no: | |

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

| Contraindications – To be filled by referring clinician | | | Implant Details (scan to proceed only if MRI conditional) To be filled by referring clinician |
|---|---|---|---|
| Does the patient have any of the following? | | | |
| A pacemaker/ICD: | ☐ Yes | ☐ No | Device |
| Cochlear Implant/Aneurysm Clip: | ☐ Yes | ☐ No | Manufacturer |
| Metallic fragments in eye(s): | ☐ Yes | ☐ No | Model |
| VP Shunt/ Neurostimulator | ☐ Yes | ☐ No | Date of implantation |
| Pregnant (if applicable): | ☐ Yes | ☐ No | **Charge code** |
| If pregnant, is it within the 1st trimester: | ☐ Yes | ☐ No | |

**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** |