MRI Request & Safety Form

Paul Strickland Scanner Centre

Mount Vernon Hospital
Northwood
Middx HA6 2RN
Tel: 01923 886311 Fax: 01923 886313

Trial name/no._____
Scan schedule day_____
Week_____
Standard of care ☐
Commercial ☐
Local ☐
NCRN ☐
RECIST Yes / No Other:_____

Patient height:

Patient weight:

This information can prevent delays due to scanner bore size restrictions

Surname:	**Ref. type:**	NHS	PP	Self-funding
First name:	**NHS no:**		
Address:	**Hosp. no:**		
ALL PATIENT DEMOGRAPHICS MUST BE COMPLETED	**Ref. hosp. / GP surg.:**		
OR THE REFERRAL MAY BE RETURNED	**Pat. type:**	Outpatient	IP – Ward: _____
Postcode:	**Accessible information req'd?**	Yes	No
Telephone no. 1:	**Mobility:**	Walking	Wheelchair Trolley
Telephone no. 2:	**Hospital transport required?**	Yes	No
DoB: Male Female Other	**For future scan in:**	(e.g. 3/12, 6/52)	

Examination required:

Brain / BOS / IAMs		Liver		Shoulder	RT	LT
Neck (soft tissue)		Pelvis (onco.)		Wrist	RT	LT
Brachial Plexus		Pelvis (ortho.)		Hips	RT	LT
Axilla		C Spine		Knee	RT	LT
Whole Body		T Spine		Ankle	RT	LT
Abdo-Pelvis		L Spine		Other:		

Reason for scan:

Clinical details:

Provisional diagnosis:

Surgery performed (date & hospital): **Previous RT/chemo (date):**

Does the patient have the capacity to consent for the requested examination? YES/NO* (Delete as appropriate)
*If NO, please provide evidence of a best interests assessment in accordance with the requirements of the Mental Capacity Act (Consent Form 4)

MRI AT PSSC MAY BE CONTRAINDICATED IF THE PATIENT HAS A:	**Renal impairment?**	Yes No	**Previous imaging**	Date:	Place:
	Creatinine:		**MRI**		
	Date:				
PACEMAKER DEFIBRILLATOR PROGRAMMABLE SHUNT BRAIN ANEURYSM CLIP(S) COCHLEAR IMPLANT	**Infection control risk?**	Yes No	**CT**		
	Height:	**Weight:**	**PET/CT**		

Referrer's name: _____ (print) **Grade/role:** _____

Referrer's signature: _____ **Date of request:** ___/___/_____

Consultant: _____ **Contact tel:** _____ **N.B. This form is a legal document**

Please ensure that the patient fills in the safety questionnaire on the reverse.

MRI SAFETY QUESTIONNAIRE

These questions are necessary for your safety; please answer them all

Name: _____ Date of Birth: _____

Please tick and if YES please provide details in the space below

	YES	NO
Have they ever had a cardiac or gastric **pacemaker**, **defibrillator**, **programmable shunt** or **cochlear implant**? (please tick YES even if the device has been removed)		
Have they had any **heart surgery**? e.g. bypass surgery or heart valve replacement		
Have they had **brain surgery**? e.g. shunts, clips on arteries or blood clots removed		
Have they had any **eye surgery**? e.g. cataracts, retinal tack		
Have they had any **ear surgery**? e.g. stapedectomy		
Have they ever had **metal fragments** in their **eyes**? (even if the fragments have been removed)		
Have they ever had any **shrapnel** or **bullet** injuries?		
Do they have any **metal** or **electronic implants**? e.g, joint replacements, pins, clips, plates or screws, baclofen pump or ECG recorder ("reveal device")		
Do they have **kidney stents**?		
Have they ever swallowed a **camera capsule / PillCam** to investigate the bowel?		
Do they have any **cosmetic enhancements**? e.g. breast or penile implants, hair extensions		
Could they be **pregnant**?		
Are they **breast-feeding** at the moment?		
Please provide details of any surgery or procedures they have **EVER** had:		

You will be asked to complete a further safety questionnaire on arrival at the Centre. You must remove all metal objects such as hair slides, jewellery, metallic body piercing, watches and electronic tags for your scan – rings of precious metal may be kept on. Please leave as many of these items at home as possible.

IF YOU HAVE ANY QUESTIONS OR HAVE ANSWERED "YES" TO ANY OF THE QUESTIONS ABOVE, PLEASE RING THE MRI UNIT ON 01923 886311

Signing below states you have answered and understood all of the questions above.

Patient signature_____ Date_____