MRI Request & Safety Form

Paul Strickland Scanner Centre
Mount Vernon Hospital
Northwood
Middlesex HA6 2RN
Tel: 01923 886311 Fax: 01923 886313

RESEARCH TRIALS

Trial name____________________

RD number: RD20_______________

Scan schedule day/week__________

Patient height:

Patient weight:

Surname:	**Ref. type:**	NHS	PP	Self-funding
First name:	**NHS no:**			
Address: ALL PATIENT DEMOGRAPHICS MUST BE COMPLETED OR THE REFERRAL MAY BE RETURNED	**Hosp. no:** **Ref. hosp. / GP surg.:** **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	Upper Abdomen (specify)	Other:
Neck (soft tissue)	Liver	
Brachial Plexus / Axilla	Pelvis (oncology - specify)	
Whole Body	Oncology Spine	
Abdo-pelvis	Bony Pelvis	

Clinical Question:

Clinical details: **RECIST REQUIRED? (tick)** **NONE** **1.1** **iRECIST**

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:			**Previous imaging**	Date:	Place:
PACEMAKER DEFIBRILLATOR PROGRAMMABLE SHUNT BRAIN ANEURYSM CLIP(S) COCHLEAR IMPLANT	**Renal impairment?**	Yes No			
	eGFR: Date:	Creatinine: Date:	**MRI**		
	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 you got a cardiac or gastric **pacemaker**, **defibrillator**, **programmable shunt** or **cochlear implant**? (please tick YES even if the device has been removed)		
Have you had any **heart surgery**? e.g. bypass surgery or heart valve replacement		
Have you had **brain surgery**? e.g. shunts, clips on arteries or blood clots removed		
Have you had any **eye surgery**? e.g. cataracts, retinal tack		
Have you had any **ear surgery**? e.g. stapedectomy		
Have you ever had **metal fragments** in your **eyes**? (even if the fragments have been removed)		
Have you ever had any **shrapnel** or **bullet** injuries?		
Do you have any **metal** or **electronic implants**? e.g, joint replacements, pins, clips, plates or screws, baclofen pump or ECG recorder ("reveal device")		
Do you have **kidney stents**?		
Have you ever swallowed a **camera capsule / PillCam** to investigate the bowel?		
Have you had any **cosmetic enhancements**? e.g. breast or penile implants, hair extensions		
Could you be **pregnant**?		
Are you currently **breast-feeding**?		
Please provide details of any surgery or procedures you 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__________________________