HARLEY STREET MEDICAL CENTRE

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MRI Referral Form

Patient details (affix label if available)

Title Other	Address:
First name:	
Surname:	Postcode:
DOB: Male ◯ Female ◯	Self pay ◯ Insured ◯ NHS ◯ Third party ◯
Contact telephone number(s):	Insurance Company:
	Policy Number:
Mobility: Mobile ◯ Non-mobile ◯	Authorisation Code:

Examination/Procedure

Open MRI ◯ Extremity MRI ◯

	Routine ◯ Urgent ◯
	Date of follow up appointment:

Relevant clinical details

Safety check as recommended by the MHRA, the referring clinician is required to assess patient safety for MRI scans.

Cardiac pacemakers, artificial heart valves, cochlear implants, cerebral aneurysm clips are contra-indicated for MRI

Does the patient have a metal implant or pacemaker? ◯ Yes ◯ No

Has the patient ever had an injury to the eye involving a metallic object? ◯ Yes ◯ No

Referring clinician's details (stamp or affix label if available)

Referrer name:		**Signature of referring clinician :**
GMC number:		
Contact Tel No:		

Please indicate how you would like to receive the results of the investigation?

◯ **By Encrypted Email** - Email Address:

◯ **By Post** - Postal Address:

CD of images will be given to the patient. Do you wish to receive a copy? ◯ Yes ◯ No

Further copies of this form are available to download at www.harleystreet-medicalcentre.com