

Radiology Department, 15 Portland Place, London W1B 1PT Mon-Fri 8:30 – 17:30 T: +44 020 3995 0225 E: ukmchreferral@mayo.edu
PATIENT INFORMATION All fields with a * are mandatory

*LAST NAME			*FIRST NAME		
*DATE OF BIRTH			GENDER	Male ☐ Female ☐ Non-Binary ☐	
INTERPRETER REQUIRED?			PHONE NUMBER		
MCH patient number (if known)			EMAIL		
*PATIENT'S ADDRESS	Address		FUNDING	SELF PAY ☐ INSURANCE ☐ CORPORATE ACCOUNT ☐ OTHER ☐	
	City		INSURANCE COMPANY		
	Postcode		MEMBERSHIP NUMBER		
	Country		Pre- authorisation number		

MRI ☐ MAMMOGRAPHY ☐ CT ☐ ULTRASOUND ☐ DXA ☐ X-Ray ☐

*Exam requested:	*Clinical Indication: Including any relevant history and investigations Additional Comments:	Preferred Radiologist:
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Critical/Urgent Finding
Contact Information (If
Different Than Below)

Investigation		MRI Contraindications- does the patient have:	
Could the Patient be Pregnant?	Yes ☐ No ☐	A pacemaker/ICD?	Yes ☐ No ☐
Is the patient breast feeding?	Yes ☐ No ☐	Allergy to contrast medium?	Yes ☐ No ☐
Is the patient a high infection risk?	Yes ☐ No ☐	Kidney disease/surgery?	Yes ☐ No ☐
If yes, please specify		A cerebral aneurysm clip?	Yes ☐ No ☐
Does the patient have any allergies?	Yes ☐ No ☐	Cochlear implants?	Yes ☐ No ☐
If yes, please specify		Neurostimulators?	Yes ☐ No ☐
Creatinine level		Programmable hydrocephalus shunt?	Yes ☐ No ☐
eGfr and date		History of working with metal?	Yes ☐ No ☐
		Metallic foreign body in eye?	Yes ☐ No ☐
		Other Metallic implants?	Yes ☐ No ☐

NB: If Yes to any of the details please inform the Imaging Department prior to the examination
REFERRING CLINICIAN DETAILS –IR(ME)R 2017 regulations require this form to be signed and dated by the referring clinician. Incomplete forms will be rejected and returned. The radiation risks must be balanced against potential benefit to the patient.

*Name		*Practice Name	
*Signature		*Address	
*GMC Number		*Phone	
*Date		*Email	