parkside hospital

MRI REQUEST FORM

Parkside Hospital & Cancer Centre London

53 Parkside Wimbledon London SW19 5NX
Telephone: 020 8971 8000

DEPARTMENT OF RADIOLOGY

Fax: 020 8947 1526
Email: radiology@parkside-hospital.co.uk

Referring Doctor

Doctor:

Address:

Tel No:

Patient Details

Surname:

First Names:

D.O.B.:

Clinic No:

Address:

Tel No:

For female patients aged 12-55 years please enter date of L.M.P.

Is there any possibility you could be pregnant YES ☐ NO ☐

PLEASE TICK APPROPRIATE BOX:	I/P ROOM NO	O/P	WALK	CHAIR	STRETCHER	PORTABLE	THEATRE
	☐	☐	☐	☐	☐	☐	☐

CLINICAL HISTORY (IRMER requires a full history):

EXAMINATION REQUESTED:

SPECIFIC QUESTION TO BE ANSWERED:

SIGN	DATE	Preferred Radiologist?

NOTE: INCOMPLETE REQUESTS WILL BE RETURNED, RESULTING IN DELAY OF BOOKING. Patients MUST bring outside Imaging for comparison

SAFETY CHECK

Does the patient have?	YES	NO		YES	NO		YES	NO		YES	NO
A cardiac pacemaker?	☐	☐	Brain and/or Spinal Surgery?	☐	☐	A cerebral aneurysm clip?	☐	☐	Other metallic implants?	☐	☐
Cochlear Implants?	☐	☐	Bladder Stimulators?	☐	☐	Neurostimulators?	☐	☐	Spinal Rods?	☐	☐
Programmable Hydrocephalus shunt?	☐	☐	Intra Orbital Foreign Body?	☐	☐	History of working with metal?	☐	☐	Artificial Heart Valves?	☐	☐

For Radiographer use only

Comments:

Coil Type:

Number of projections sent: