MAYO CLINIC HEALTHCARE

# DIAGNOSTIC IMAGING REFERRAL FORM

Radiology Department, 15 Portland Place, London W1B 1PT T: 020 7871 2575 E: ukmchreferral@mayo.edu

| PATIENT INFORMATION | | | |
|---|---|---|---|
| LAST NAME | | FIRST NAME | |
| DATE OF BIRTH | | FEMALE / MALE | M ☐ F ☐ |
| INTERPRETER REQUIRED? | | PHONE NUMBER | |
| PATIENT'S ADDRESS | | EMAIL | |
| | | FUNDING | SELF PAY ☐ INSURANCE ☐ CORPORATE ACCOUNT ☐ OTHER ☐ |
| | | INSURANCE COMPANY | |
| | | MEMBERSHIP NUMBER | |
| | | Pre- authorisation number | |

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

| Exam requested: | **Clinical Indication:** Including any relevant history and investigations |
|---|---|
| | |

| Critical/Urgent Finding Contact Information (If Different Than Below) | |
|---|---|

| Investigation | |
|---|---|
| Could the Patient be Pregnant? | Yes ☐ No ☐ |
| Is the patient breast feeding? | Yes ☐ No ☐ |
| Is the patient a high infection risk? | Yes ☐ No ☐ |
| If yes, please specify | |
| Does the patient have any allergies? | Yes ☐ No ☐ |
| If yes, please specify | |
| Creatinine level | |
| eGfr and date | |

| TO BE COMPLETED FOR ALL MRI EXAMINATIONS<br>MRI Contraindications- does the patient have: | | |
|---|---|---|
| A pacemaker? | Yes | ☐ |
| A cerebral aneurysm clip? | Yes | ☐ |
| Cochlear implants? | Yes | ☐ |
| Neurostimulators? | Yes | ☐ |
| Programmable hydrocephalus shunt? | Yes | ☐ |
| History of working with metal? | Yes | ☐ |
| Metallic foreign body in eye? | Yes | ☐ |
| Other Metallic implants | Yes | ☐ |

**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. Please note the referring clinician will assume responsibility for all follow-up care.

| Name | | Address | |
|---|---|---|---|
| Signature (must be in ink) | | Tel | |
| Date | | Email | |