SPRINGFIELD HOSPITAL

RAMSAY HEALTH CARE

Ramsay Health Care Imaging Request Form—MRI

Springfield Hospital
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Patient Details

Patient No: .....

Surname: .....

Forename: .....

Address.....

Postcode:.....

DOB: ..... Sex: .....

Hospital Information

Ward/Dept/Hospital:.....

Clinic date: .....

Special requirements:

.....

.....

MRI Contraindications

Cardiac pacemaker?	Yes	No	Diabetic?	Yes	No
Previous neurosurgery?	Yes	No	Cross infection risk?	Yes	No
Hydrocephalus shunt?	Yes	No	Any renal impairment?	Yes	No
Cochlear implant?	Yes	No	Creatinine level/eGFR: _____	Date: _____	
Metallic foreign body in the eye?	Yes	No	(only of already known and tested within 3 months)		
Any possibility of pregnancy	Yes	No	LMP: _____		

Comments _____

_____

Examination Requested: _____

Clinical History and question to be answered:

Referring Practitioners Details

Referrers Name: _____ Referrers Signature: _____

Date: _____ Title: _____ Telephone: _____

Address: _____

_____

Protocol/ Radiographer instructions:

Appointment details: