

MRI Request Form

Safety Checklist: Referrers must complete the following MRI safety questions to comply with the RCR guidelines and MHRA to ensure patient safety before the procedure.

Patient Details		Safety Checklist	
First name		Does the patient have a cardiac pacemaker?	Yes <input type="radio"/> No <input type="radio"/>
Surname		Does the patient have aneurysm clips or hydrocephalus shunt?	Yes <input type="radio"/> No <input type="radio"/>
Address		Has the patient had a cochlear implant?	Yes <input type="radio"/> No <input type="radio"/>
Postcode		Has the patient had a neurostimulator implant?	Yes <input type="radio"/> No <input type="radio"/>
Date of birth	Male <input type="radio"/> Female <input type="radio"/>	Is there a history of metallic foreign bodies in the eye?	Yes <input type="radio"/> No <input type="radio"/>
Tel (home)		Is the patient pregnant?	Yes <input type="radio"/> No <input type="radio"/>
Mobile		Is the patient claustrophobic?	Yes <input type="radio"/> No <input type="radio"/>
Email		Other metallic implant	Yes <input type="radio"/> No <input type="radio"/>
Self-pay <input type="radio"/> Insured <input type="radio"/>		If yes please specify any other implant...	
Insurers name			
Policy number			

Referral Information

Centre	Oxford <input type="radio"/> Windsor <input type="radio"/>
Please specify the reason for referral	

Area(s) to be scanned

Additional Information

Required urgently?	Yes <input type="radio"/> No <input type="radio"/>	Preferred date
IV Contrast needed?	Yes <input type="radio"/> No <input type="radio"/>	
For patient having IV Contrast, does the patient suffer from any allergies, renal disease, diabetes or are they breast-feeding?		

Referring Consultant Details

Name	Please specify how you would like to receive the clinical report: Email <input type="radio"/> Post <input type="radio"/> Fax <input type="radio"/> By signing, you have understood the contraindications for MRI scanning and are authorising GenesisCare to undertake the scan requested. Signature _____ Date _____
Address	
Postcode	
Email	
Tel	

Please post, fax or email this form to GenesisCare, MRI Department:

Windsor: GenesisCare, 69 Alma Road, Windsor, Berkshire, SL4 3HD **Phone:** 01753 418444 **Fax:** 01753 864 306 **Email:** windsor.enquiries@genesiscare.com

Oxford: GenesisCare, Sandy Lane West, Peters Way, Littlemore, Oxford, OX4 6LB **Phone:** 01865 237 700 **Fax:** 01865 770 016 **Email:** oxford.enquiries@genesiscare.com

GenesisCare use only

Exam approved	Yes <input type="radio"/> No <input type="radio"/>	Standard sequence <input type="radio"/> Standard sequence and review <input type="radio"/>
Date	If for review, radiographers / radiologist's notes	
Time of appointment		

Click here to send the completed form to either:
oxford.enquiries@genesiscare.com windsor.enquiries@genesiscare.com