**Croydon MRI Centre**

**Patient Referral Form**

**WARNING**

Cardiac pacemakers, Cerebral aneurysm clips and Metallic foreign bodies in the eye are ABSOLUTE CONTRA-INDICATIONS for MRI.

**Patient Details:** Hospital No:

**Referring Consultant:**

Croydon University Hospital London Road, Thornton Heath Surrey

CR7 7YE

Tel: +44 (0)20 8401 3696

Fax: +44 (0)20 8401 3697

Full name: Address:

Postcode: Daytime Telephone: Evening Telephone: Date of Birth: Male Female

Name: Address for films and report:

Postcode: Telephone: Fax:

**Inpatients:**

**Outpatients:**

Is there a possibility of Pregnancy?

Yes

No

Ward:

Hospital:

Transport required? Yes

No

Mode of Transport: Walking

Trolley

Chair

Bed

**Preferred Consultant Radiologist:**

**Examination Requested:**

Urgent

Routine

**Please specify whether conventional or open MRI required (delete as appropriate)**

Area(s) to be examined/scanned:

Clinical Details:

Previous Surgery (please specify):

Previous Imaging(please specify):

**SIGNATURE: DATE: PRINT NAME BLEEP/EXTENSION NO:**

Please fax completed forms (two pages) to fax number as above.

 Funding Authorisation:

 **Patient funding (please delete as appropriate):**

Self Funded Insured NHS Funded

 **Referral Details**

 Number of parts to be scanned 1 2 3 4 5 6

 Parts to be scanned: Please specify ...................................................................................................

 **Reasons for an Open MRI scan:**

 Claustrophobic Bariatric Other (please delete as appropriate)

 Cost £ \_\_\_

 **Billing/approval information for NHS patients**

 Hospital, Trust, etc (full details please): ....................................

 Department: ...............................................................

 Address : ...................................................................

 ......................................................................................

 PO/Reference: ................................................................

 Contact Name: .................................................

 Contact Position: .............................

 Contact Number: ..............................................

 Email: ....................................................

 By signing below you are duly authorising lnHealth to undertake the scan requested by the referring clinician.

 Signature of Approving Contact

 ....................................................................................

 (Please print name after signature)

 **This authorisation form has to be completed and presented with the referral request. Please note that we are unable to scan NHS patients without prior funding authorisation.**

Please fax completed forms (two pages) to fax number as above