**MRI Referral Form**



Clinical Imaging Facility,

Ground Floor ILS 2, College of Medicine

Swansea University, SA2 8PP

Tel: 01792 606420

Email: CIFGroup@swansea.ac.uk

|  |  |
| --- | --- |
| **Patient name:****Surname/ Forename** |  |
| **Date of Birth:** |  | **Male/ Female** |  | **Height** |  | **Weight** |  |
| **Address:****Postcode:** |  |
|
| **Email:** |  | **Tel:** |  |

**All referrals must come from a registered medical professional. We cannot accept self-referrals.**

|  |  |
| --- | --- |
| **Referrer Name:** |  |
| **Practice name & address** |  |
| **Job Title /Reg No** |  |
| **Primary Contact****Number & Email** |  |
| **2nd Email OR Mobile number** |  |
| **Signature:** |  |
| **Date:** |  |

|  |  |  |
| --- | --- | --- |
| **Please state whether you need:** | **Images *AND* Scan Report** | **Scan report *ONLY*** |
|  |  |

|  |  |
| --- | --- |
| **Area to be scanned:** |  |
| **Clinical Indications :****(present and any past details relevant to area to be imaged). Please continue below if necessary.** |
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**You must complete on sections on Page 2 (Below).**

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| **Safety Questions - To be completed for all MRI Examination requests** *(indicate any of the following)*  |
| **Pacemaker?** | Yes | No | **Metallic foreign body in the eye?** | Yes | No |
| **Previous Heart surgery**  | Yes | No | **Any Metallic pins, plates or implants?** | Yes | No |
| **Previous Brain surgery** | Yes | No | **Pregnant?**  | Yes | No |

|  |  |  |
| --- | --- | --- |
| **Funding:**  | Self Funding | Insurance Company Name:Authorisation No:  |
| University Internal Transfer: Budget Code: ………………………………….. College Dept: …………………………………………………………..Dept Authorising Manager Print: ………………………………… .Signature: …………………………….. |

**Please note:** Uninsured patients and patients without pre-authorisation are required to pay on the day of their appointment. Insured patients are liable for any fees not covered by their insurer. Please therefore ensure that cover is in place prior to booking a scan appointment.

**We are currently moving to an electronic system for the sending of images and scan reports. It is essential that a secure 2nd email *OR* mobile phone number is provided for this purpose. Please be aware that all sections MUST be completed. Incomplete referrals will not be accepted and will be returned for completion.**

**Clinical indications, continued -**

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| --- |
| **Patient Name & DOB:** |
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