YORK DIAGNOSTIC IMAGING

MRI Imaging Request Form

YDI no. YDI ___

Patient Name:				Title		
Date of Birth:		Gender (M/F)				
Patient Address:						
Tel no. (Home)		Tel no. (Work)				
Tel no. (Mobile)						
Who is responsible for the patient's account?		Patient	x	Other		
If other please specify:						
Clinical Details:						
Provisional Diagnosis:						
Part(s) to be imaged:						

IMPORTANT: MRI examinations **CANNOT** be carried out on patients with cardiac pacemakers, cerebral aneurysm clips, cochlear implants or intra-ocular metallic fragments. By signing this form the referrer confirms (please tick):

- ☐ **The patient has no known contra-indications to having an MRI examination.**
- ☐ **The patient has the capacity to give consent to the procedures.**
- ☐ **The patient does not require an interpreter.**
- ☐ **The patient has sufficient mobility to position themselves on the scan bed**

If the patient does not meet all of the above criteria, please contact us to see if arrangements can be made. Please note also that in the case of interpreters, the CQC recommends that this is an independent person (i.e. not a friend or family member).

Signature:		Date:	
Name of referring Clinician (PRINT)			
Address for report			
Referrer Tel no.		Referrer Fax no.	

T: 01904 435346 F: 01904 435356 email :reception@yorkmri.co.uk

Please telephone York Diagnostic Imaging to discuss your patient's referral or fax this completed form and we will contact the patient directly to make an appointment.

Registered with Care Quality Commission
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