THE COLNE CLINIC

Imaging Request Form

Appointment Date: **Time:**

Patient Details

Surname: _____ First Name: _____

Title: _____ DOB: _____ Male ☐ Female ☐ Patient ID No. _____

Address _____

_____

_____ Postcode _____

Home Tel _____ Work Tel _____ Mobile Tel _____

MRI		ULTRASOUND		XRAY		OTHER	

Clinical Details _____

_____

_____

Provisional Diagnosis _____

Area to be scanned _____

Referring Clinicial Declaration

Does the Patient Have:	Yes	No
- A Cardiac Pacemaker	☐	☐
- A Cochlear Implant	☐	☐
- Metallic Fragments In Eyes	☐	☐

Allergies: Give details _____

	Yes	No
- Any Metallic Implants	☐	☐
- 1st Trimester Pregnancy	☐	☐

- Other: Give details _____

IMPORTANT: MRI examinations CANNOT be carried out on patients with: cardiac pacemakers, cerebran aneurysm clips, cochlear implants, intra-ocular metallic fragments or in the 1st trimester of pregnancy.

Female Patients: I have no reason to believe I am pregnant. Signature _____ **Date** _____

Referring Clinicial / Speciality _____

Name: _____

Address For Report: _____

_____

_____ Telephone _____ Fax _____

Referring Clinician Signature _____ **Date** _____

FOR OFFICE USE ONLY

Appointment Details _____

_____

Date _____

Radiologist's Protocol _____

Radiographer/Comments _____

_____

Exposures _____

Dose _____ Screening Time _____ Contrast Yes ☐ No ☐

Imaging No.

Radiographer signature

Appointment confirmed ☐ No contraindications ☐

Please send or fax to 45 Station Road, Wraysbury, Staines, Middlesex TW19 5ND. Fax: 01784 483377 www.thecolneclinic.co.uk