

Request Form: CT, MRI, Ultrasound & X-Ray

Please complete all sections of this request form
Signed forms may either be faxed to +44 (0)20 7935 7715 or posted to:
Alliance Medical Imaging Centre, 10-11 Bulstrode Place, London W1U 2HX

Patient details

Name:

Address

Postcode:

Tel:

Mobile:

Email:

Date of birth:

Male / Female:

Start date of Last Menstrual Period (if applicable):

Patient arrival: Trolley Wheelchair Walking

Funding: NHS Self Funded Private Patient

Patient's insurance company:

Membership number:

Pre-authorisation number (if known):

Please note: Uninsured patients and patients without pre-authorisation are required to pay on the day of their appointment.

Referral information

Type of examination requested: CT MRI X-Ray
Ultrasound

Areas to be imaged:

Reason for referral:

Creatinine level: Date of test:.....

Relevant previous medical history

Details (including any surgery and current medication):

Please include copies of any recent X-Rays or scan reports

Safety check

Could the patient be pregnant? Yes No

Is the patient breast feeding? Yes No

Is the patient a high infection risk? Yes No

If yes, please specify:

Is the patient diabetic? Yes No

Is the diabetes controlled by: Diet Insulin Tablet

Is the patient on Metformin? Yes No

Does the patient have any allergies? Yes No

If yes, please specify:

MRI Contra-indications - does the patient have:

A Pacemaker? Yes No

A Cerebral Aneurysm Clip? Yes No

Cochlear Implants? Yes No

Neurostimulators? Yes No

Programmable Hydrocephalus Shunt? Yes No

Metallic Foreign body in eye? Yes No

Other metallic implants? Yes No

Referring Clinician's details

IR(ME)R 2000 regulations require this form to be signed by the referring Clinician.

Consultant name:

Signature:

Date:

Hospital (if applicable):

Address:

Tel:

Email:

Fax: