Radiology Request Form
West Middlesex MRI

Please tick as appropriate:

MRI ☐ DEXA ☐

Area to be examined: _____

Patient Name: _____ Hospital Number: _____

Date of Birth: _____ Title: _____ Male ☐ Female ☐

Patient Address: _____

_____

_____ Postcode: _____

Telephone Numbers

Home: _____ Work: _____ Mobile: _____

In-patient: _____ Ward: _____ Name of Hospital: _____

_____ Telephone: _____

Who is responsible for the patient's account? Patient: ☐ NHS: ☐ Other: ☐

Please note any contradictions for MRI e.g. intra-orbital foreign bodies, intra-cranial aneurysm clip, pacemaker, cochlear implants, prosthetic heart valve, pregnancy, or any recent surgery: _____

_____

Clinical Information: _____

_____

_____

Referrer's Signature: _____ Date: _____

Name of Referring Clinician: _____ Telephone Number: _____

Address for Report: _____

_____

_____ Postcode: _____

Appointment Details: _____

_____

Females 12-55 years LMP Date

Are you Pregnant? Yes ☐ No ☐

Billing Code: _____

Reporting Radiologist: _____

To be completed by the radiographer

Operator: _____

Dose: _____

Date of Scan: _____

Please send or fax this form to:

West Middlesex MRI

West Middlesex University Hosital, Twickenham Road, Isleworth, Middlesex TW7 6AF

Tel: 020 8560 9722 Fax: 020 8568 6586 Email: wmri@alliance.co.uk