Imaging Request Form
Wythenshawe Cardiac MRI

Alliance Medical

Patient Details

NHS No: _____ RM2: _____

Surname: _____

Forename: _____

Address: _____

_____ Postcode : _____

D.O.B: _____ Sex: _____

Tel No: _____

Hospital Information

Ward/Dept/Hospital: _____

Clinic return date: _____

Referring Consultant: _____

Previous Coronary Angiogram/ECHO/SPECT Date Nr/Findings:

_____

_____

_____

MRI Contra-indications - does the patient have:

A cardiac pacemaker?	Yes ☐	No ☐	Is the patient diabetic?	Yes ☐	No ☐
A history of neurosurgery?	Yes ☐	No ☐	Is there a cross-infection risk? (eg MRSA)	Yes ☐	No ☐
A neurostimulator?	Yes ☐	No ☐	Can the patient breath-hold?	Yes ☐	No ☐
Programmable hydrocephalus shunt?	Yes ☐	No ☐	Does the patient have renal impairment?	Yes ☐	No ☐
Metallic foreign body in the eye (ever)?	Yes ☐	No ☐	Creatinine level: _____	Date: _____	
A cochlear implant?	Yes ☐	No ☐	eGFR: _____	Date: _____	
Surgery within the last 3 months?	Yes ☐	No ☐	Interpreter required? If yes, specific language: _____		
Could the patient be pregnant?	Yes ☐	No ☐	Any other special requirements (eg mobility): _____		

Does the patient have any STENTS or REPLACEMENT HEART VALVES? Yes ☐ No ☐

If yes please provide details of make/model: _____

Examination Details

Examination requested: _____

Clinical history and indication for the examination: _____

_____

_____

Question to be answered: _____

_____

Referring Practitioner's Details

Referrers Name: _____ Referrers Signature: _____

Title/Grade: _____ Pager/Bleep/Telephone: _____ Date : _____

For CMR Use: Supervised: ☐ Unsupervised: ☐ Urgent : ☐

Exam Code: _____ Routine: ☐

Signed : _____ Suspend: ☐

PRISM ☐ **DMS** ☐

Date: _____ Time: _____

Short Notice: ☐ Confirmed: ☐

Please send or fax this form to:

Cardiac MRI Centre, North West Heart Centre, Wythenshawe Hospital,
UHSM NHS Foundation Trust, Southmoor Road, Manchester M23 9LT.
Tel: 0161 291 4560 E: admin.wyth@alliance.co.uk