MAYO CLINIC HEALTHCARE

DIAGNOSTIC IMAGING REFERRAL FORM

Radiology Department, 15 Portland Place, London W1B 1PT Mon-Fri 8:30 – 17:30 T: +44 020 3995 0225 E:ukmchreferral@mayo.edu

PATIENT INFORMATION	All fields with a * are mandatory			
*LAST NAME			*FIRST NAME	
*DATE OF BIRTH			GENDER	Male ☐ Female ☐ Non-Binary ☐
INTERPRETER REQUIRED?			PHONE NUMBER	
MCH patient number (if known)			EMAIL	
*PATIENT'S ADDRESS	Address		FUNDING	SELF PAY ☐ INSURANCE ☐ CORPORATE ACCOUNT ☐ OTHER ☐
	City		INSURANCE COMPANY	
	Postcode		MEMBERSHIP NUMBER	
	Country		Pre- authorisation number	

MRI ☐ **MAMMOGRAPHY** ☐ **CT** ☐ **ULTRASOUND** ☐ **DXA** ☐ **X-Ray** ☐

*Exam requested:	*Clinical Indication: Including any relevant history and investigations Additional Comments:	Preferred Radiologist:

Critical/Urgent Finding Contact Information (If Different Than Below)	

Investigation	
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	
Does the patient have any allergies?	Yes ☐ No ☐
If yes, please specify	
Creatinine level	
eGfr and date	

MRI Contraindications- does the patient have:	
A pacemaker/ICD?	Yes ☐ No ☐
Allergy to contrast medium?	Yes ☐ No ☐
Kidney disease/surgery?	Yes ☐ No ☐
A cerebral aneurysm clip?	Yes ☐ No ☐
Cochlear implants?	Yes ☐ No ☐
Neurostimulators?	Yes ☐ No ☐
Programmable hydrocephalus shunt?	Yes ☐ No ☐
History of working with metal?	Yes ☐ No ☐
Metallic foreign body in eye?	Yes ☐ No ☐
Other Metallic implants?	Yes ☐ No ☐

NB: If Yes to any of the details please inform the Imaging Department prior to the examination

REFERRING CLINICIAN DETAILS – IR(ME)R 2017 regulations require this form to be signed and dated by the referring clinician. Incomplete forms will be rejected and returned. The radiation risks must be balanced against potential benefit to the patient.

*Name		*Practice Name	
*Signature		*Address	
*GMC Number		*Phone	
*Date		*Email	