MRI, CT, X-Ray, Fluoroscopy, Ultrasound

10-11 Bulstrode Place, London W1U 2HX

european scanning centre
A NEW ERA IN DISEASE PREVENTION AND DETECTION

Bookings : tel: **0845 456 8878** fax: **+44 (0)20 7935 7715** email: **appointments@europeanscanning.com**

Patient details

Name: _____

Date of Birth: _____

Address: _____

_____

_____ Postcode: _____

Tel: _____ Mobile: _____

Email: _____

Male ☐ Female ☐

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 requested to pay on the day of their appointment.

Referral information

☐ MRI ☐ CT ☐ X-Ray ☐ Ultrasound ☐ Fluoroscopy

Area under examination:

e-GFR value: _____

Date of test:

Reason for referral:

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 taking Metformin? Yes ☐ No ☐

Does the patient have any allergies? Yes ☐ No ☐

If yes, please specify: _____

To be completed for all MRI examinations

MRI Contraindications - 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: _____

Address: _____

_____

Tel: _____

Fax: _____

Email: _____