UPRIGHT MRI centres

MRI REFERRAL FORM

London	**Tel:** +44 (0)20 7637 2888	**Fax:** +44 (0)20 7637 5888
Leeds	**Tel:** +44 (0)113 231 1902	**Fax:** +44 (0)872 023 3863

This referral is for ☐ **London** ☐ **Leeds**

PLEASE COMPLETE ALL SECTIONS ON THIS REQUEST FORM - THANK YOU

Patient details		
Mr / Mrs / Miss / Ms / Dr / Other	Address	
First Name		
Surname	Postcode	
INSURED / NHS / SELF-PAY / EMBASSY		
DOB	Insurance Company	
Landline number	Policy number	
Mobile number	Male	Female
Email	Mobility	Mobile / Non-Mobile
Examination and clinical details		
Routine / Urgent	Date of follow-up appointment	
Area to be scanned:		
Clinical indications:		
Safety details		
Check for cochlear implants, aneurysm clips, pacemaker		
I confirm that **I am not pregnant**	Signed:	Radiographer Initials:
Have you ever had metallic objects enter your eye?		
Is contrast required? YES / NO	**If yes and over 65 yrs of age please check GFR**	
Referring clinician's details		
Name (please print)	Report sent by FAX / EMAIL / POST	
Address	Fax number	
Email	Signature	
Contact number	Date	

Bupa AXA AVIVA PRUHEALTH WPA simplyhealth CIGNA Aetna