# IMAGING REFERRAL

THE MONTEFIORE HOSPITAL
Part of Spire Healthcare

The Montefiore Hospital
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|---|---|---|---|
| **INSURANCE PROVIDER:**<br>Policy number:<br>Authorisation code (if any): | | **SELF-PAY:** | **OTHER** (please state): |
| **To comply with IR(ME)R regulations and local policy please complete all sections accurately below this line. Incomplete or unsigned forms will be returned to the referrer. Please use patient identification label wherever possible.** | | | |
| **SAP NUMBER:**<br>**SURNAME:** **TITLE:**<br>**FORENAME:**<br>**ADDRESS:**<br>*affix patient label here*<br>**EMAIL:** | | **Date of Birth:**<br>**Telephone Number/s:**<br>**LMP Date:**<br>**Patient signature:**<br>Date:<br>**To the best of my knowledge, I am not pregnant.** | |
| **EXAMINATION REQUESTED** (please specify modality and body part) | **MRI** | **Ultrasound** | |
| | **CT** | **X-Ray / Fluoroscopy / Mammography** | |
| **CLINICAL INFORMATION**<br>Please write clearly and **do not use abbreviations** IR(ME)R 17 requirement | | | |
| **eGFR**<br>Result:<br>Date:<br>(required for all CT & MRI scans using contrast) | **Contraindications/safety for MRI – Does the patient have any of the following? CIRCLE ALL THAT APPLY:**<br>• Pacemaker<br>• Internal cardiac defibrillator<br>**Please be aware that we DO NOT have facilities to enable us to scan these patients safely.**<br>• Cochlear implant<br>• Programmable hydrocephalus shunt<br>• Neuro stimulator<br>• Cerebral aneurysm clip<br>**Please be aware that we will need the make, model number and insertion date for these devices in order to assess safety to scan.** | | |
| **REFERRED BY:** (PRINT NAME) | **SIGNATURE:** | **DATE:** | |
| **REFERRED TO:** (Please circle) | **ICON / SPRING / SIP / Cardiac / Neuro / Vascular / Breast** | | |
| **Preferred Radiologist/Cardiologist (if any):** | | | |
| ***DIAGNOSTICS USE ONLY:*** | | | |
| *Radiographer(s)* | | *Appointment date & Time:* | |
| *Dose/Screening time:* | | *Appt & prep info sent (email/text)* | |
| ***Radiologist** Print name & sign* | | ***Radiologist Protocol:*** | |