THE New Foscote HOSPITAL

Email completed form to

foscote.radiology@nhs.net or radiology@thefoscotehospital.co.uk

Imaging Request Form

Patient Surname:		**Referring Clinician:**	Hospital Number:
Patient Given Name:	**DOB:**		
Patient Address:		Patient Contact Details:	
	Postcode:	Sex:	Is this case urgent? Y N

Referrer's declaration (NB: This form is a legal document)
I have discussed the examination with the patient/guardian. Examinations can NOT be performed without sufficient clinical information and a doctor's signature in line with Ionising Radiation (Medical Exposure) Regulations 2000.Correct patient details have been given (Areas in **BOLD** must be completed).

Examination(s) requested (*If for MRI or for Injection please complete below):

Relevant Clinical Information and Clinical Question

Referrers Signature: Date:

***Warning MRI:**

Does the patient have a cardiac pacemaker?	Y	N	Has the patient had any brain surgery?	Y	N
Does the patient have artificial heart valve?	Y	N	Has the patient got any metal in their body?	Y	N
Has the patient ever had metal fragments in their eyes?	Y	N			

***Patients undergoing injections:**

Warfarin/blood thinning medicines?	Y	N	Epilepsy/backouts/fits?	Y	N
Allergies?	Y	N	Driving home?	Y	N
Asthmatic	Y	N	Steroid injection in the last 3 months?	Y	N
Heart disease/high blood pressure?	Y	N			

FOR OFFICE USE ONLY

Received	Sent for Vetting	Vetted by	Contacted Patient	Appointment booked	Imaging performed by	Sent for reporting	Reported by	Report sent to referrer

Vetting outcome:

Date:

Patient prep:

Radiographer/Operator: Date of examination:

Operator Use: Dose (cGycm^2):

kVp: mAs:

Screening time: Number of Exposures Accepted: Rejected:

THE New Foscote HOSPITAL
The New Foscote Hospital, 2 Foscote Rise, Banbury, Oxfordshire OX16 9XP Tel 01295 252281

MRI Safety Screening Form

The following questionnaire is designed to identify metallic items in the body that may cause harm if taken into the MRI scanner magnetic field. Please read the Patient Information Leaflet 'MRI Examination' which explains the examination and safety precautions required. You **must complete** this questionnaire before your appointment and contact the Radiology department if you answer '**YES**' to any of the questions from 1 to 5, so there is no delay or postponement to your scan.

QUESTIONS – please tick yes or no in the columns provided	YES	NO
Have you ever been fitted with a cardiac (heart) pacemaker or implant defibrillator (ICD)? **If YES**, please describe. You must **tell staff IMMEDIATLEY**		
Have you ever undergone any surgery or other procedures to your heart? **If YES**, **please describe**, including any dates and where this was carried out		
Have you ever had any of the following medical implants:		
Aneurysm clip		
Programmable hydrocephalus shunt		
Cochlear implant		
Neurostimulator		
Implantable drug infusion pump		
Have you **EVER** had any metal fragments in your eyes? If you answered **YES** – did you seek medical and did a doctor tell you everything had been completely removed? If **YES**, you may need an x-ray, **speak to staff IMMEDIATLEY**.		
Have you had any other surgery to your head or spine? (including eyes and ears) If **YES**, please describe:		
Have you ever suffered from epilepsy or have you ever had a fit/blackout?		
Have you ever had any shrapnel (fragment of metal) injuries to your body?		
Have you had any operations that involved metal clips, pins, plates or other implants? (including any joint replacements) If **YES**, please describe:		
Have you had any operations or other medical procedures in the last 6 months?		
Do you wear a medicine patch? (Fentanyl, nicotine, HRT etc)		
Do you have any tattoos, permanent cosmetics or piercings?		
Female patients only: Is there a possibility of you being pregnant?		

If you have answered **YES** to any questions from 1-5, please contact the MRI department immediately.

Forename……

Surname……

Date of birth……..

Address……

……

……

Weight……KG Height……

To be completed at appointment only:

The MRI scan procedure has been explained to me by the radiographer; I have removed all metal objects (mobile phone, jewellery, hearing aids, metal dentures, prosthetic limb etc) and have answered the questions above to the best of my knowledge.

Patient signature……

Date: ……

Radiographer signature……

Date: ……