



Please complete all sections of this request form. Signed forms can be faxed or posted

Diagnostic Imaging 353.1.5262060 / diagnosticimaging@sportsurgeryclinic.com

Patients Details

Name: Male/Female: Start date of Last Menstrual Period (if applicable):
Address: Patient arrival: Trolley Wheelchair
Postcode: Tel: Funding: Self Funding Other
Mobile: Email: Walking
Date of birth: Other

Referral Information

Type of Examination requested: 3T MRI CT X-Ray US DEXA

Area to be imaged:

Reason for referral:

Relevant previous medical history

Details (including any surgery and current medication):

Please include copies of any recent X-Rays or scans

Safety check

Is the patient diabetic and on metformin? Yes No
Could the patient be pregnant? Yes No
Is the patient breast feeding? Yes No
Does the patient have any allergies? Yes No
If yes, please specify:

MRI Contra-indications - does the patient have:

A Pacemaker Yes No
A Cerebral Aneurysm Clip Yes No
Eye and Ear Implants Yes No
Neurostimulators Yes No
Metallic foreign body in eye Yes No
Other metallic implants Yes No

Referring Clinician's details

Referring Physicians Name: Hospital (if applicable):
Telephone: Address:
Fax: Email:
Signature: Date: