Request Form: Diagnostic Imaging

SPORTS SURGERY CLINIC

Specialists in Joint Replacement, Spinal Surgery, Orthopaedics and Sport Injuries

Please complete all sections of this request form. Incorrectly completed forms will be returned.

Radiology tel: 01 526 2060 / radiology@sportssurgeryclinic.com / fax: 01 526 2061

Name: | Sex: M ☐ F ☐

Address: | Date of Birth: __ __ / __ __ / __ __ __ __

Finance: Club affiliation: ☐ Insurance: ☐ Self Pay: ☐

Insurance Type/No:

Tel: | Mobile: | Email:

REFERRAL INFORMATION

MRI ☐ CT ☐ X-ray ☐ US ☐ DEXA ☐ Interventional ☐

Examination Requested: (e.g. MRI Right Knee)

Reason for referral (Clinical indication):

MRI Contrast Renal Risk Questions:			MRI Contraindications:		
Any history of Renal dysfunction?	Yes ☐	No ☐	Pacemaker/Heart Valve/Defibrillator (ICD)	Yes ☐	No ☐
Is the patient over 70 years?	Yes ☐	No ☐	Cerebral Anuerysm Clip	Yes ☐	No ☐
Is the patient a medicated Diabetic?	Yes ☐	No ☐	Eye and/or ear implants	Yes ☐	No ☐
Is the patient on medication for Hypertension?	Yes ☐	No ☐	Neurostimulators	Yes ☐	No ☐
***If yes to any of these questions eGFR is required**			Other metallic implants	Yes ☐	No ☐

REFERRING CLINICIANS DETAILS	
Name:	Hospital (if applicable):
Telephone:	Address:
Fax:	
Email:	
Signature:	Date:

Office Use

Date & time Slot Held: ☐ In-patient: ☐ Ward: ☐ PRP: ☐ PAC: ☐

Blood Thinners: ☐ Specify: ☐ Quote/Cost: ☐ Amount quoted: ☐ Bring images: ☐ Driving: ☐