# Imaging Request Form
# Ashford & St. Peter's MRI

Alliance Medical

Patient Name: _____ Title: _____

Date of Birth: _____ Male ☐ Female ☐

Patient Address: _____

_____

_____

_____ Postcode: _____

Telephone Numbers

Home: _____ Work: _____

In-Patient: ☐ Ward: _____ Name of Hospital: _____

Hospital Number: _____ Tel. Number: _____

Who is responsible for the patient's account? Patient ☐ Other ☐

Clinical Details: _____

_____

_____

Provisional Diagnosis: _____

_____

Part(s) to be imaged: _____

Priority: Urgent ☐ Routine ☐

## Important

MRI Examinations cannot be carried out on patients with: cardiac pacemakers, cerebral aneurysm clips, cochlear implants, intra-ocular metallic fragments. Please note table weight limit of 39 stones (250 kgs) and maximum patient girth of 86 inches (220cms).

Signature: _____ Date: _____

Name of Referring Consultant: _____ Tel. Number: _____

Address for Report: _____

_____

_____ Postcode: _____

Appointment booked for: _____

Appointment confirmed ☐ No contraindications ☐

Ashford & St. Peter's MRI will contact the patient direct either by letter or telephone to make an appointment.

Please send or fax this form to:

Ashford & St. Peter's MRI
Departmental Block, Level 2, St. Peter's Hospital, Guildford Road, Chertsey, Surrey KT16 0PZ
Tel: 01932 726930 Fax: 01932 726939 Email: aspmri@alliance.co.uk