Appt date:_____ Time:_____ ID No: _____

Ex-Scan UK
MRI request form

Please ring and fax request through to Ex-Scan UK
Telephone 01204 488211 Fax 01204 488363

PERSONAL DETAILS	
Patient name:	DOB:
Address:	Telephone:
	Mobile:
	GP:
Postcode:	Practice:
Male/Female	Weight:
INSURANCE	
Insured: Yes/No	Insurance company:
Policy number:	Authorisation number:
REFERRING CLINICIANS DETAILS	
Referring clinicians name:	
Address:	Telephone:
	Fax:
Is a report of the scan required from Ex-Scan UK? Yes/No	
Who would you like to report the scan?	
Address for report:	
CLINICAL INDICATIONS	
Area to be scanned:	Right/left/both
Clinical information:	
Previous surgery:	
Contraindications: (please complete prior to request) Cardiac pacemaker **YES/NO**, Intracerebral aneurysm clips **YES/NO**, Ever worked with metal **YES/NO**, Artificial heart valve **YES/NO**, Neurotransmitters **YES/NO**, Cochlear implants **YES/NO**	
Could the patient be pregnant: Yes/No	How many weeks?
Clinicians signature:	
Date:	
FOR OFFICE USE ONLY:	
Date request received:	Radiographer:
Protocols:	
Reporting Radiologist:	