first contact health

SCANNING + DIAGNOSIS + TREATMENT

MRI Extremity Scanning Referral Form

Patient Details			
Title		Funding Details	
First Name		Self Funding	☐
Surname		Insured	☐
Date of birth		Insurer:	
Telephone			
Email Address		Policy Number:	
Address			
		Office use - Auth Code	
Postcode			

Clinical history and presentation:

Clinical question to be answered:

Region/s to be scanned:	Specific area/s of interest:

NB Gadolinium administration will not be available in this facility

Safety questions	
If YES to any of the following, please phone to discuss - it is the expectation that scanning will be unable to proceed	
Does the patient have a cardiac pacemaker, aneurism clip, ventriculoperitoneal shunt, cochlear implant, or neurotransmitter?	Yes: ○ No: ○
Has the patient had recent surgery (Within the last 6 weeks)?	Yes: ○ No: ○
Is the patient within the 1st trimester of pregnancy?	Yes: ○ No: ○
Does the patient have the presence of metal shards in their eyes?	Yes: ○ No: ●

Referrer Details			
Title		Signature	
Name			
Speciality			
Practice address		Date:	
		Send report by:	
Telephone		Email:	☐
Email Address		Post:	☐
Fax		Fax:	☐

Click here to submit form - or send to imaging.Guernsey@FirstContactHealth.com

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