

## Open / Upright – MRI REFERRAL FORM

Please note: this service does not accept urgent referrals. All referrals are booked in and treated as routine.

Please note – we are unable to accept referrals for breast MRI

### Symptoms indicative of / suspected Cauda Equina?

Yes

No

Please note – we are unable to accept referrals where cauda equina syndrome is the working diagnosis of or suspected by the referrer or in patients where the symptoms are indicative of it. Please redirect any referral to the appropriate provision

PATIENT		REFERRER	
NHS Number		Name	
Forename		GMC/HPC/NMC No	
Surname		Address	
Address			
Date of Birth		Referring CCG Code	
Telephone (Home)		Referring Practice Code	
Telephone (Work)		Telephone No. (for urgent clinical findings)	
Telephone (Mobile)		Fax No.	
E-mail Address		NHS.net mail only	
Gender	Male <input type="checkbox"/> Female <input type="checkbox"/>	If interpreter required, language:	
Physical/Communication difficulties (specify if any):		Height:	Weight:
Mobility difficulties (specify if any):			
Ethnicity			

Please provide any additional relevant clinical information that may assist with the interpretation of the referral and images.

**Investigation(s) Required:** tick investigation required; please indicate which side of body and body part where appropriate.

Brain	<input type="checkbox"/>	Foot	L <input type="checkbox"/> R <input type="checkbox"/>	Sacroiliac Joints	<input type="checkbox"/>
IAMS	<input type="checkbox"/>	Ankle	L <input type="checkbox"/> R <input type="checkbox"/>	<b>Contrast required</b>	
Cervical spine	<input type="checkbox"/>	Knee	L <input type="checkbox"/> R <input type="checkbox"/>	Other (state body part and body side):	
Thoracic spine	<input type="checkbox"/>	Hips	L <input type="checkbox"/> R <input type="checkbox"/>		
Lumbar spine	<input type="checkbox"/>	Hand	L <input type="checkbox"/> R <input type="checkbox"/>		

**All referrers must complete the following MRI safety questions:**

- Does the patient have any implanted metallic foreign devices? (e.g. cardiac pacemaker, artificial heart valve, cerebral aneurysm clips, cochlear implant etc) **YES / NO**
- Is the patient known to have metallic fragments in their eyes? **YES / NO**
- Could the patient be pregnant? **YES / NO**

Date of Referral:

**Signature:**

Please e-mail this form to the appropriate clinic:

The London Upright MRI Centre [info@uprightmri.co.uk](mailto:info@uprightmri.co.uk)

The Birmingham Upright MRI Centre [birminghaminfo@uprightmri.co.uk](mailto:birminghaminfo@uprightmri.co.uk)

The Leeds Upright MRI Centre [leedsinfo@uprightmri.co.uk](mailto:leedsinfo@uprightmri.co.uk)

[www.uprightmri.co.uk](http://www.uprightmri.co.uk)

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