	CAPPAGH NATIONAL ORTHOPAEDIC HOSPITAL, FINGLAS, DUBLIN 11. **The Sisters of Mercy**	Founded 1908
RF-RAD-05	**MRI Request Form**	**ISSUE DATE: 29/07/2015**
REVISION NO: 2		**NEXT REVIEW: 07/2017**

MRI DEPARTMENT: MRI REQUEST FORM

Phone: 01 8140361 Fax: 01 8140364 E-mail: mri@cappagh.ie

PATIENT DETAILS:		
Name:	**Date of Birth:**	**Hospital Number:**
Address:		
Phone Number:	**Referring Consultant:**	

OTHER HOSPITALS:			
Source of Referral:	**Inpt:** ☐	**Outpt:** ☐	**Purchase Order No.:**
Mobility:	**Walking** ☐	**Wheelchair** ☐	**Trolley** ☐

PATIENT SAFETY SCREENING:			
	Y/N		***Y/N***
Pacemaker/defibrillator		**Diabetes/heart disease/kidney disease**	
Intra cranial aneurysm clips/neurostimulator		**Recent surgery (in the past 6 weeks)**	
Artificial heart valve/cardiac stents		**MRSA**	
Eye/ear implant		**Claustrophobia**	
Ever had metallic fragments in eyes/skin		**Pregnant/breastfeeding**	
Ever had allergic reaction to contrast agent		**Serum Creatinine*:**	

MRI EXAMINATION REQUIRED:

CLINICAL INFORMATION/INDICATION:

*Serum Creatinine (within 6 weeks of scan date) is required if Gadolinium Contrast is indicated in the following patient groups: ● patients 65yrs and above ● patients who have a history of renal disease ● patients who are in the perioperative liver transplantation period. If you have any queries please ring the MRI Department.

Referrer's Signature: _____ **Date:** _____

Bleep Number: _____ **Phone:** _____

Hospital/Department: _____ **Fax:** _____