NATIONAL ORTHOPAEDIC HOSPITAL CAPPAGH	RF-RAD-05:	
	Revision Number:	
	Issue Date:	
	Next Review:	
National Orthopaedic Hospital Cappagh, Finglas, Dublin 11.	MRI REQUEST FORM	
MRI DEPARTMENT: 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:	Input:	Output:	Purchase Order No:
Mobility:	Walking:	Wheelchair:	Trolley:

PATIENT SAFETY SCREENING	Yes/No		Yes/No
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:** _____