UME Health
Tomorrow's health starts here

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Imaging Referral Form

Patient details (affix label if available)

Date of referral:

Title:	Address:
First name:	
Surname:	
DOB: Male ◯ Female ◯	Postcode:
Contact telephone number(s):	Self pay ◯ Insured ◯ NHS ◯ Third party ◯
	Insurance Company:
Email:	Policy Number:
Mobility: Mobile ◯ Non-mobile ◯	Authorisation Code:

Examination/Procedure

3T MRI ◯ CT ◯ X-ray ◯ Ultrasound ◯ Fluoroscopy ◯

Body Part:	**Clinical indication:**

Diagnostic Tests

◯ ECG	◯ Dobutamine stress echocardiogram	◯ 72-hour ECG monitor
◯ Exercise Stress ECG	◯ Echocardiogram bubble study	◯ 7-day ECG monitor
◯ Echocardiogram	◯ 24-hour ECG monitor	◯ 14-day ECG monitor
◯ Exercise stress echocardiogram	◯ 48-hour ECG monitor	◯ 24-hour BP monitor

Contrast investigations

For patients above 65 years of age or with any known problems with kidney function, serum creatinine level or eGFR must be available prior to imaging.

Serum creatinine/eGFR reading: _____ Date taken: _____

Safety check as recommended by the MHRA, the referring clinician is required to assess patient safety for MRI scans.

Cardiac pacemakers, artificial heart valves, cochlear implants, cerebral aneurysm clips are contra-indicated for MRI

Does the patient have a metal implant or pacemaker? ◯ Yes ◯ No

Has the patient ever had an injury to the eye involving a metallic object? ◯ Yes ◯ No

Referring clinician's details

Referrer name:		**Referrer signature:**		**Date:**	
GMC number:		**Contact Tel No:**			

Please indicate how you would like to receive the results of the investigation?

◯ **By Encrypted Email** - Email Address:

◯ **By Post** - Postal Address:

CD of images will be given to the patient. Do you wish to receive a copy? ◯ Yes ◯ No