QUEEN SQUARE IMAGING CENTRE

Queen Square Imaging Centre
8-11 Queen Square
London
WC1N 3AR

020 7833 2513
020 7837 8074
www.queensquare.com

Magnetic Resonance Imaging (MRI) Referral Form

Please complete this form with all known details and return to imaging@queensquare.com or by fax to 020 7837 8074

Patient Details

Title: **Please select**

Surname:

Forename:

Date of Birth: / /

Mobility: **Please select**

Is the patient? : **Please select**

Insurance Details (If applicable)

Medical Insurer Name:

Hospital Number:

Address:

Postcode:

Telephone:

Email:

Membership Number:

Examination/Procedure

Area to be examined:

Relevant Clinical Details:

If contrast is required:

eGFR Result: on: / /

Date of follow up: / /

Safety Check:

Has the patient had:

Any heart surgery or a pacemaker ?

Any injury involving metal in the eye ?

Please contact the Imaging Centre if there are any concerns over a contra-indication to MRI

Have any previous scans been uploaded to PACS or sent to the Imaging Centre for review? ?

Referral Details

Referrer Name:

Referrer GMC Reg :

Report and CD to be returned to:

Signature of Referring Clinician:

Date of Request: / /

Queen Square Imaging Centre Staff Use:

QSIC Patient Number:

Appointment:

Billing:

Radiographer Initials: