QUEEN SQUARE
PRIVATE HEALTHCARE

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 by fax to **020 7837 8074** or by email to imaging@queensquare.com.

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: