Vista HEALTH
accessible | affordable | assuring

REFERRAL FORM

PATIENT DETAILS

Mr Mrs Miss Dr Other (please specify):
First name:
Surname:
Date of birth:
☐Male ☐Female
Email:
Telephone:
Address:
Post code:
Policy number:
Authorisation code:
Self-pay/Insured:
Insurer name:

Please state which preferred site or tick if any site is acceptable ☐

RELEVANT CLINICAL DETAILS

***Please ensure these boxes are completed**

*Justification for scan:

*Region(s) to be scanned:

MRI☐ Ultrasound☐ Echo☐ X-Ray☐ 24hr BP monitoring☐ CT☐ 12hr ECG☐ 24hr ECG☐ 48hr ECG☐ DEXA☐

Urgent scan? ☐Yes ☐No

Additional requirements ☐3T MRI ☐Arthrogram ☐ Prostate imaging

Is Gadolinium required? ☐Yes ☐No

MHRA guidelines recommend all patients (particularly those over 65) should be screened for renal dysfunction by obtaining a history, laboratory testing or both

Relevant previous imaging ☐ None / ☐ Film / ☐ Digital **Date:**

SAFETY CHECK as recommended by the MHRA, the referring clinician is required to assess patient safety for MRI scans

Does the patient have a cardiac pacemaker or valve?	☐Yes	☐No	If 'yes' – unable to proceed with scan
Does the patient have an intracranial aneurysm clip or a programmable ventriculoperitoneal shunt?	☐Yes	☐No	If 'yes' – unable to proceed with scan
Has the patient had a cochlear implant or neurotransmitter?	☐Yes	☐No	If 'yes' – unable to proceed with scan
Does the patient have renal impairment?	☐Yes	☐No	If 'yes' – an extrapolated GFR should be determined from the serum creatinine and discussed with LCAD
Has the patient had surgery in the last 6 weeks?	☐Yes	☐No	If 'yes' – unable to proceed with scan
Is there a history of metallic foreign bodies in the patient's eye?	☐Yes	☐No	If 'yes' – it is mandatory to exclude metallic orbital foreign bodies by orbital X-ray. If no metallic foreign body is detected, scan can proceed. If detected, unable to proceed
Is the patient breastfeeding?	☐Yes	☒No	If 'yes'- intravenous contrast cannot be administered while breastfeeding and the patient should contact LCAD for instructions
Is the patient pregnant?	☐Yes	☐No	If yes please note that we cannot proceed with scan
Is the patient involved in paid professional sports?	☐Yes	☐No	

REFERRING CLINICIAN'S DETAILS

Mr Mrs Miss Dr Other (please specify):
Referrer name:
Specialty/profession:
Registration code:
Hospital/practice:
Email:
Address:
Post code:
Tel:
Fax:

Please confirm how you would like to receive the report by ticking below:
☐**Email** ☐**Post**
Do you want the report sent to another clinician? ☐Yes ☐No
If yes please give full details:

Signature:
Date:

If requesting an MRI referral for the above patient I have understood the contraindications for MRI scans and, where requested, the implications and side effects associated with the administration of intravenous Gadolinium.

When completed - please email this form to booking@vistahealth.co.uk | T 0333 200 2064 | www.vistahealth.co.uk