Vista HEALTH

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Payment method - please tick
Self-pay ☐
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Invoiced (pre agreed) ☐

REFERRAL FORM

PATIENT DETAILS

Mr Mrs Miss Dr Other (please specify) .....
First name .....
Surname .....
Date of birth ..... Male/Female .....
Email .....
Telephone .....
Address .....
..... Post code .....

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

Policy number .....
Authorisation code .....
Self pay/Insured .....
Insurer name .....

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 12 Lead ECG 24hr ECG 48hr ECG DEXA Cardiac MRI Endoscopy

Urgent scan? Yes No

Additional requirements 3T MRI Arthogram 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, valve or stent?	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 patients 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

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** **Fax**

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@vista-health.co.uk or fax it to 0333 200 2065

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