Vista Health
Leading the way in healthcare

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 ☐ 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, 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

Vista Health, 1st Floor, Capital Tower, 91 Waterloo Road, London SE1 8RT
T 0333 200 2064 | F 0333 200 2065 | Email: booking@vista-health.co.uk | www.vista-health.co.uk