

# SCANNING AT THE MR THERAPY CENTRE

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MRI REQUEST FORM

## PRIVATE MRI REQUEST FORM

Please ensure you state how you wish to receive the report.  
For urgent appointments, please telephone 0207 886 7605/7606.  
Otherwise, please fax this form to 020 7886 7607.

PATIENT SURNAME:	.....	FIRST NAMES:	.....
PATIENT ADDRESS:	.....	DOB:	DD / MM / YY
	.....	MALE / FEMALE:	.....
	.....	OFFICE / HOME No:	.....
	.....	MOBILE No:	.....
	.....	REFERRING HOSPITAL:	.....

REFERRING CONSULTANT:	.....		
	PP / OTHER	INPATIENT / OUTPATIENT	WALKING / CHAIR / TROLLEY
AREA(S) TO BE SCANNED:	.....		
CLINICAL DETAILS :	.....		
(PREVIOUS SURGERY)	.....		
	.....		
INFORMATION REQUIRED:	.....		
	.....		
	.....		
PREVIOUS SCANS/X-RAYS:	.....		
HAS THE PATIENT A PACEMAKER / PROSTHESIS / IMPLANT?	.....		

SIGNATURE:	.....	REPORT VIA:	TEL / FAX / EMAIL / POST?
CONSULTANT:	.....	ADDRESS DETAILS:	.....
			.....
		TEL:	.....
DATE:	DD / MM / YY	FAX:	.....

### MR THERAPY CENTRE

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