

Patient Referral

Patient details			
Mr Mrs Ms Miss Dr Other (please specify)		Mobility: Mobile ☐ Non-mobile ☐	
First Name:		Funding: Self-pay ☐ Insured ☐ NHS ☐ Embassy ☐	
Last Name:			
Date of birth:	Male ☐ Female ☐	Insurance company:	
Address:		Policy no:	
		Pre-authorization no:	
Postcode:		Comments:	
Tel:		Mobile:	Email:
Region to be scanned			
Urgent ☐ Non-urgent ☐ Flexion & Extension ☐			
Relevant clinical details – What information are you seeking from this examination?			
Previous relevant surgery:			
Safety check (as recommended by the MHRA, the referring practitioner is required to assess patient safety for MRI scans)			
Cardiac pacemakers, spinal cord stimulators, cerebral aneurysm clips, metallic heart valves, cochlear implants are contra-indications for MRI.			
Possibility of pregnancy?:		Yes ☐ No ☐	
Referring practitioner			
Mr Mrs Miss Dr Other (please specify)		How would you like to receive the report?	
Name:		Email ☐ Post ☐ Fax ☐	
Practice/Hospital:		Report to be given to patient? Yes ☐ No ☐	
Address:			
Postcode:			
Email:			
Tel:	Fax:		
Patient Referrals	Email:	london.centre@medserena.co.uk manchester.centre@medserena.co.uk	
London:	Tel:	020 7370 6003	
	Fax:	020 7373 0339	
Manchester:	Tel:	0161 434 8039	
	Fax:	0161 434 8579	
		Signature:	
		Date:	