

**EXTERNAL REFERRAL FORM FOR CARDIAC MAGNETIC RESONANCE**

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| **PATIENT DETAILS** |  |
| Name:  | D.O.B: |
| Address: | NHS number:  |
| Post Code: |  |
| Patient Contact Number: |  |

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| **REFERRING CONSULTANT:** |
| **REFERRING HOSPITAL**: Kingston / St Helier / Epsom / Royal Surrey / Frimley / East Surrey / Lewisham/ QMH / Nelson / Croydon / Other……………………... |

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| **EXAMINATION REQUESTED:** (Please indicate if perfusion CMR required) |
| **INDICATION FOR REFERRAL:** (State the problem and the questions to be answered) |

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| **CONTRAINDICATIONS TO MRI** |
| Previous surgery  | □ | Neurostimulators | □ |
| Metal in situ  | □ | Cerebral aneurysm clips  | □ |
| Artificial heart valve  | □ | Cochlear implants  | □ |
| Cardiac pacemakers  | □ |  |  |
| **Pregnancy: Y** □ **/ N** □ |  |

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| **FOR IV CONTRAST EXAM** |
| **Renal impairment: Y** □ **/ N** □ |
| **Creatinine level:**(If this information is not available, gadolinium will not be administered ) |
| **Contrast allergy: Y** □ **/ N** □ |

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| **Signed** | **Job title:** |
| **Print Name:** | **Bleep:** |
| **Date:** |  |

**INCOMPLETE FORMS WILL BE RETURNED TO REFERRER AND INVESTIGATION NOT BOOKED**

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| **SGH Department of Radiology- DEPARTMENTAL USE ONLY** |
| **Examination justified: Y/N** | **Operator signature:** |
| **Protocol:** | **Cardiologist** |
| **Cardiologist’s signature:** | **Dose:** |