

Appt:		

Clinically urgent referral

Old Watton Road Colney Norwich NR4 7TD 01603 255 531

No

Yes

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Spire Hospital number: Examination required: Examination required: Examination required: First names: Address/Room — IP OP OP Address/Room — IP OP OP Postcode: Telephone number(s) Home: Made Female Date of birth: Is a language interpreter required? Ves No If yes, which language is required? Ves No If yes, which language is required? Ves No OR Sign: Date: Address for report/films: Date: To the best of my knowledge I am not pregnant to the best of my knowledg						
Address/Room number IP OP Clinical information: Postcode: Telephone number(s) Home: Work: Any previous imaging undertaken relating to this referral?If 'yes' please provide details, ie NNUH, Spire etc.: Yes No If yes, which language is required? Yes No If yes, which language is required? Yes No If yes, which language is required? CAR Sign: Date: To the best of my knowledge I am not pregnant Additional information/implant information:	Spire Hospital number:	Title:	Title: Surname:			
Clinical information: Postcode: Telephone number(s) Home: Work:	Examination required:	First names:				
Postcode: Telephone number(s) Home: Work: Male Female Date of birth: Is a language interpreter required? Yes No If yes, which language is required? LMP date: Specific radiologist required: Referring clinician: Address for report/films: OR Sign: Date: To the best of my knowledge I am not pregnant Additional information/implant information:		Address/Room number		IP	OP	
Postcode: Telephone number(s) Home: Work: Male Female Date of birth: Is a language interpreter required? Yes No If yes, which language is required? LMP date: Specific radiologist required: Referring clinician: Address for report/films: OR Sign: Date: To the best of my knowledge I am not pregnant Additional information/implant information:						
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Address for report/films: Address for report/films:		Sign:		Date:		
Additional information/implant information: Address for report/films:	Referring clinician	To the best of my knowledge I am not pregnant				
		Additional information/implant information:				
Sign: Date:	Address for report/films:					
Sign: Date:						
		Sign:		Date:		

MRI / CT contraindications	Please tick and complete the following			
Do you have a cardiac pacemaker or other cardiac device?	Yes No			
Do you have an internal hearing device?	Yes No			
Do you have any other type of electronic implant?	Yes No			
Have you ever had metal enter your eyes or body?	Yes No			
If 'yes' to any of the above please provide details:				
Are you pregnant?	Yes No			
Height: Weight:				
eGFR is required for ALL patients over 65 years and any patient with renal impairment receiving contrast in both MRI and CT.				
Result:	Date obtained:			