



Magnetic Resonance Imaging (MRI) Referral Form

Please complete this form with all known details and return by fax to 020 3874 2441 or by email to referrals@cheniesmews.com

Patient Details

Title: _____ Hospital Number: _____
Surname: _____ Address: _____
Forename: _____
Date of Birth: / / Postcode: _____
Mobility: _____ Telephone: _____
Is the patient? : _____ Email: _____
Insurance Details (If applicable)
Medical Insurer Name: _____ Membership Number: _____

Examination/Procedure

Area to be examined: _____
Relevant Clinical Details: _____

If contrast is required:
eGFR Result: on: / /
Date of follow up: / /
Safety Check:
Has the patient had:
Any heart surgery or a pacemaker
Any injury involving metal in the eye

Please contact the Imaging Centre if there are any concerns over a contra-indication to MRI

Referral Details

Referrer Name: _____ **Signature of Referring Clinician:** _____
Report and CD to be returned to: _____
Date of Request: / /

Chenies Mews Imaging Centre Staff Use:

CMIC Patient Number: _____ Billing: _____
Appointment: _____ Radiographer Initials: _____