Referral for

image diagnostics

Patient data

Name:		Civil. Reg. no.
Address:		Postcode/town:
Tel.: Home:	Mobile:	Work:
Email:		

Type of examination

▌MRI	▌CT	

(MRI and CT: In connection with kidney disease, diabetes, hypertension, gout and >64 years, s-creatinine blood test must be provided – max 7 days old)

▌Ultrasound	▌Conventional X-ray	▌Clinical mammography

Special note re referral for MRI scan

The referring physician must review the MRI control form with the patient. It must be sent with a copy of the notes. The notes must contain a section "Referral to MRI scan", including the indication for the MRI scan.

Details about the type of implanted material must be requisitioned by the referring physician. Pacemaker and any type of magnetic device are contra-indications.

Referral

Desired examination:

Brief anamnesis:

Pregnancy

Known pregnancy: ▌Yes ▌No Pregnancy week:

Previous relevant examinations:

▌Yes ▌No If Yes, at which hospital/clinic?

Referral data

Referring physician:	Date:
Address/unit:	

Pre-MRI control form

The referring physician must review this form with the patient. It must be sent with a copy of the notes. The notes must contain a section "Referral to MRI scan", including the indication for the MRI scan. Details about the type of implanted material must be requisitioned by the referring physician. Pacemaker and any type of magnetic device are contra-indications.

Patient data

Name:	Civil Reg. no.:
Weight:	Height:

Has the patient

Pacemaker	Yes	No
Aneurism clips	Yes	No
Cochlea implant	Yes	No
Artificial heart valves	Yes	No
Other foreign metal objects in body – which and where?	Yes	No
Pregnancy	Yes	No
Claustrophobia	Yes	No
Diagnosed kidney disorder*	Yes	No
Diagnosed allergies	Yes	No
Diagnosed diabetes*	Yes	No
Diagnosed hypertension (high blood pressure)*	Yes	No
Diagnosed gout*	Yes	No

If the response is Yes to any of the items marked with an asterisk (*) and the patient is to have contrast agent administered, there must be a serum creatinine test that is no more than 7 days old.
Patients over 64 years old: A serum creatinine test must be available.

Medication as contra-indication for contrast agent If Yes, state which medication:	Yes	No

Supplementary information:

If the patient wishes to have next of kin present during the examination, the next of kin must also complete the control form.

I, the Undersigned, confirm that I have reviewed the above control form and that there are no contra-indications for MRI scanning. The patient is informed about the examination and the risks associated with it.

Date: _____ Physician's/radiographer's signature: _____