

10-11 Bulstrode Place, London W1U 2HX

email: [info@londoncardiacimaging.com](mailto:info@londoncardiacimaging.com)

Patient details	
Name: _____	Male <input type="checkbox"/> Female <input type="checkbox"/>
Date of Birth: _____	Start date of last Menstrual Period (if applicable) _____
Address: _____	Funding: Self Funded <input type="checkbox"/> Private Patient <input type="checkbox"/>
_____	Patient's insurance company: _____
_____ Postcode: _____	Membership number: _____
Tel: _____ Mobile: _____	Pre-authorization number (if known): _____
Email: _____	<b>Please note:</b> Uninsured patients and patients without pre-authorization are requested to pay on the day of their appointment.

Type of Scan	Reason for referral:
<input type="checkbox"/> Stress CMR <input type="checkbox"/> Non-Stress CMR <input type="checkbox"/> Hypertension CMR  <input type="checkbox"/> Ca Score + CTCA <input type="checkbox"/> Ca Score Only	
e-GFR value: _____	
Date of test: _____	

Relevant previous medical history
Details (including any surgery and current medication):   
Please include copies of any recent X-Rays or scan reports

Safety check	To be completed for all MRI examinations
Could the patient be pregnant?    Yes <input type="checkbox"/> No <input type="checkbox"/> Is the patient breast feeding?    Yes <input type="checkbox"/> No <input type="checkbox"/> Is the patient a high infection risk?    Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please specify: _____ Is the patient diabetic?    Yes <input type="checkbox"/> No <input type="checkbox"/> Is the diabetes controlled by:    Diet <input type="checkbox"/> Insulin <input type="checkbox"/> Tablet <input type="checkbox"/> Is the patient taking Metformin?    Yes <input type="checkbox"/> No <input type="checkbox"/> Does the patient have any allergies?    Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please specify: _____	<b>MRI Contraindications</b> -does the patient have: A pacemaker?    Yes <input type="checkbox"/> No <input type="checkbox"/> A cerebral aneurysm clip?    Yes <input type="checkbox"/> No <input type="checkbox"/> Cochlear implants?    Yes <input type="checkbox"/> No <input type="checkbox"/> Neurostimulators?    Yes <input type="checkbox"/> No <input type="checkbox"/> Programmable hydrocephalus shunt?    Yes <input type="checkbox"/> No <input type="checkbox"/> Metallic foreign body in eye?    Yes <input type="checkbox"/> No <input type="checkbox"/> Other metallic implants?    Yes <input type="checkbox"/> No <input type="checkbox"/>

Referring Clinician's details	
IR(ME)R 2017 regulations require this form to be signed by the referring clinician  Consultant name: _____  Signature: _____ Date: _____	Address: _____ _____ Tel: _____ Fax: _____ Email: _____