

RADIOLOGY SERVICES

PATIENT DETAILS

Name: _____ Date of Birth: ____/____/____

Address: _____

Phone: _____ MRN: _____

Previous Patient at Limerick Clinic: Yes No Finance: Insurance Self Pay

Date Requested: ____/____/____ Insurance Type / No: _____

REFERRAL INFORMATION

MRI X-Ray Ultrasound

EXAMINATION REQUESTED: (please clearly state anatomical area of interest e.g. MRI Brain)

REASON FOR REFERRAL (Clinical Indication):

CONTRAST RENAL RISK QUESTION: (MRI Potential Contraindications)

Any history of Renal Impairment	Yes <input type="checkbox"/> No <input type="checkbox"/>	Pacemaker/Heart Valve/Defibrillator (ICD)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is the patient over 65 years	Yes <input type="checkbox"/> No <input type="checkbox"/>	Cerebral Aneurysm Clip	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is the patient a Diabetic	Yes <input type="checkbox"/> No <input type="checkbox"/>	Eye/Ear implants	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is the patient on Anti-hypertensives	Yes <input type="checkbox"/> No <input type="checkbox"/>	Neurostimulators	Yes <input type="checkbox"/> No <input type="checkbox"/>
*If yes to any of these questions eGFR is required.		Other metallic implants	Yes <input type="checkbox"/> No <input type="checkbox"/>

REFERRING CLINICIANS DETAILS

Name:	Hospital (if applicable):
Telephone:	Address:
Fax:	
Email:	GP: <input type="checkbox"/> Consultant: <input type="checkbox"/> Other: <input type="checkbox"/>
Signature:	Date:

Please complete all sections of this referral form, incomplete referrals will be returned.