MRI REQUEST FORM

The Worcestershire Imaging Centre, Orchard House, Victoria Square,
Droitwich Spa, Worcestershire, WR9 8DS

Please email this form to wic.sec@nhs.net

For Office Use only MRI No:	
WIC:	

PATIENT DETAILS			
NHS Number:			
Surname:			
First Name:			
Address:			
Postcode:			
Date of Birth:		Gender:	
Telephone No:	Work:		
	Mobile:		
	Home:		

GP DETAILS	**PRIVATE INSURANCE DETAILS**
Name of GP:	Name of company:
Name of Surgery:	
Address:	Member/Policy no:
	Authorisation no:

MANDATORY INFORMATION - TO BE COMPLETED BY CLINICIAN

Risk Factors (Please select Yes or No)

If you answer 'yes' to any of the following, please contact MRI unit for guidance **01905 771500**

Pacemaker	○ Yes	○ No
Cochlea Implant	○ Yes	○ No
Neurostimulator	○ Yes	○ No
Other head or heart surgery	○ Yes	○ No
Metal fragments in eye	○ Yes	○ No
Metal prothesis	○ Yes	○ No
Pregnancy	○ Yes	○ No
Has the patient has a blood test in the last 3 months? (Regarding diabetes or renal function.)	○ Yes	○ No

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PATIENT REFERRAL

CLINICAL DETAILS & INDICATION	
CLINICAL DIAGNOSIS	AREA OF EXAMINATION

REFERRING CLINICIAN			
NAME		EMAIL	
LOCATION		DATE OF REFERRAL	
PHONE NUMBER		SIGNATURE PRINT NAME TO SIGN	

WIC REFERRAL FORM VERSION 3
Amended Sept 2019