


	<b>CAPPAGH NATIONAL ORTHOPAEDIC HOSPITAL, FINGLAS, DUBLIN 11. <u>The Sisters of Mercy</u></b>	 Founded 1908
<b>RF-RAD-05</b>	<b>MRI Request Form</b>	<b>ISSUE DATE: 24/02/2011</b>
<b>REVISION NO: 1</b>		<b>NEXT REVIEW: 02/2013</b>

**MRI DEPARTMENT: MRI REQUEST FORM**

Phone: 01 8140361/2      Fax: 01 8140364      E-mail: [mri@cappagh.ie](mailto:mri@cappagh.ie)

<b>PATIENT DETAILS:</b>		
<b>Name:</b>	<b>Date of Birth:</b>	<b>Hospital Number:</b>
<b>Address:</b>		
<b>Phone Number:</b>	<b>Referring Consultant:</b>	

<b>OTHER HOSPITALS:</b>			
<b>Source of Referral:</b>	<b>Inpt:</b> <input type="checkbox"/>	<b>Outpt:</b> <input type="checkbox"/>	<b>Purchase Order No.:</b>
<b>Mobility:</b>	Walking <input type="checkbox"/> Wheelchair <input type="checkbox"/> Trolley <input type="checkbox"/>		

<b>PATIENT SAFETY SCREENING:</b>			
	<i>Y/N</i>		<i>Y/N</i>
<b>Pacemaker/defibrillator</b>		<b>Diabetes/heart disease/kidney disease</b>	
<b>Intra cranial aneurysm clips/neurostimulator</b>		<b>Recent surgery (in the past 6 weeks)</b>	
<b>Artificial heart valve/cardiac stents</b>		<b>MRSA</b>	
<b>Eye/ear implant</b>		<b>Claustrophobia</b>	
<b>Ever had metallic fragments in eyes/skin</b>		<b>Pregnant/breastfeeding</b>	

<b>MRI EXAMINATION REQUIRED:</b>
<b>CLINICAL INFORMATION/INDICATION:</b>

**Referrer's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Bleep Number:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
**Hospital/Department:** \_\_\_\_\_ **Fax:** \_\_\_\_\_