

Date Received:	Date to be scanned by:
Appointment site:	Appointment date/time:

PO Box 2636, Tauranga 3140  
0800 467 4260  
Phone: 07 578 0273  
Fax: 07 571 4614

# MRI SCAN REQUEST FORM

Patient label		Date of request:					
		Referrer:		Signature:			
		CC Reults to:					
ACC Number:		DOI:		Medical Insurance Company:			
<b><u>Brain</u></b> <input type="checkbox"/> Brain <input type="checkbox"/> MS Screen <input type="checkbox"/> Acoustic <input type="checkbox"/> Pituitary <input type="checkbox"/> TLE <input type="checkbox"/> Cerebral Angio <input type="checkbox"/> Carotid Angio <input type="checkbox"/> Venogram <b><u>Other Please specify:</u></b>		<b><u>Spine</u></b> <input type="checkbox"/> C Spine <input type="checkbox"/> T Spine <input type="checkbox"/> L Spine <input type="checkbox"/> S I Joints <input type="checkbox"/> Pelvis  <b><u>Chest</u></b> <input type="checkbox"/> Breast <input type="checkbox"/> Other  <input type="checkbox"/> Whole Body STIR <input type="checkbox"/> Angiography:		<b><u>Musculo-skeletal</u></b> <input type="checkbox"/> Knee R L <input type="checkbox"/> Hip R L <input type="checkbox"/> Ankle R L <input type="checkbox"/> Foot R L <input type="checkbox"/> Wrist R L <input type="checkbox"/> Elbow R L <input type="checkbox"/> Shoulder R L <input type="checkbox"/> Brachial Plexus Other  <b><u>Arthrogram</u></b> <input type="checkbox"/> Shoulder R L <input type="checkbox"/> Hip R L		<b><u>Pelvis</u></b> <input type="checkbox"/> MP Prostate <input type="checkbox"/> Prostate staging <input type="checkbox"/> Rectal Staging <input type="checkbox"/> Anorectal Fistula <input type="checkbox"/> Female Pelvis  <b><u>Abdomen</u></b> <input type="checkbox"/> MRCP (non contrast) <input type="checkbox"/> Pancreas <input type="checkbox"/> Liver <input type="checkbox"/> Enterography	
<b><u>Clinical Indications</u></b>				Radiologist Approved:			
				Radiologist Grading:			
				Radiologist Protocol:			
				Contrast: Dotarem      Multihance  Y      N      +/-			
<b><u>Priority</u></b>		<b>Does your patient have:</b>		<b>MRT Comments</b>			
Urgent (1-3 days):							
Semi urgent (1-2 weeks):							
Routine:							
Specified date:							
		Cardiac Pacemaker		Y / N			
		Cerebral aneurysm clips		Y / N			
		Cardiac Surgery		Y / N			
		Any metal in their body		Y / N			
		Hx of intraocular foreign bodies		Y / N		WBH      Grace	
		Renal impairment    eGfr:		Y / N		NBH      Buscopan	