



Imaging Request Form

Please return this form completed and signed by
fax to **01902 695679** or post to:
NX Imaging Ltd, PO Box 13526, Birmingham, B16 6DP
Tel No. **01902 695935**

Patient Details:

Name: _____ Male/Female _____

Address: _____ Start date of last menstrual period: _____

Funding Self Pay Private

Patients Insurance Company: _____

Membership number: _____

Postcode: _____

Tel: _____ Pre-authorisation number (if known): _____

Mobile _____

Date of birth: _____

Referral information

Type of examination requested _____

Area to be imaged _____

Clinical indications _____

Relevant past history / surgery _____

Safety check

Biohazard Yes / No

Is the patient pregnant Yes / No

Is the patient breast feeding Yes / No

Is the patient a diabetic Yes / No

Is the patient taking metformin Yes / No

Does the patient have renal impairment Yes / No

Does the patient have any allergies Yes / No

If so please specify _____

MRI safety check - does the patient have

A pacemaker Yes / No

A metallic foreign body in eye Yes / No

A cerebral aneurysm clip Yes / No

A programmable hydrocephalus shunt Yes / No

A cochlear implant Yes / No

A metallic implant Yes / No

A neurostimulator Yes / No

Referring Clinician's details

Name: _____ Address: _____

Signature: _____

Date: _____ Tel: _____

Email: _____ Fax: _____