GROSVENOR ORTHOPAEDIC PARTNERS

Grosvenor Imaging Request Form

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Please email completed form to imaging@gop.health

Tel: 0203 926 5615

Preferred Imaging Centre:

Name:	D.O.B:	Sex: M ☐ F ☐ O ☐	
Address:			
Tel.:	Email:		
☐ PMI:	Membership №:	Authorisation №:	
☐ 3rd Party:			
☐ Self-Pay			

Modality: US ☐ MRI ☐ CT ☐ X-Ray ☐ Fluoroscopy ☐

Area to be imaged/Procedure:

Clinical Indications:

Relevant previous medical history: (Including surgery or current medication)

Please provide a copy or details of relevant previous imaging

Safety Check List				***MRI Contraindications***		
Patient L.M.P Date:				Does the patient have:		
Could the patient be pregnant?	Yes ☐	No ☐		A pacemaker?	Yes ☐	No ☐
Is the patient breast-feeding?	Yes ☐	No ☐		Cerebral aneurysm clip?	Yes ☐	No ☐
Does the patient have any relevant allergies?	Yes ☐	No ☐		Cochlear implants?	Yes ☐	No ☐
If yes, please specify:				Neurostimulators?	Yes ☐	No ☐
Is the patient diabetic?	Yes ☐	No ☐		Programmable hydrocephalus shunt?	Yes ☐	No ☐
If yes, is the diabetes controlled by:	Metformin ☐	Insulin ☐	Diet ☐	Known metallic foreign body in eyes?	Yes ☐	No ☐
Is the patient on anti-retroviral therapy:	Yes ☐	No ☐		Other possible magnetic metallic implants?	Yes ☐	No ☐
Patient's medication:						
This is to ensure a steroid injection will not adversely interact with patient's therapy.				e-GFR value:		
Does the patient have an infection?	Yes ☐	No ☐		Date of test:		
Is the patient on antibiotics?	Yes ☐	No ☐				

Referring Clinician's Details IR(ME)R 2017 regulations require this form to be signed by the referring clinician.

Referrer's Name:	Clinic Address:
Registration №:	
Signature:	
Date:	Tel:
Email report to:	IEP Images to: