Please complete the relevant sections and send to: (please insert provider name and location)

Provider Name: Cobalt Health (Imaging Centre) *Provider Location:* Linton House, Cheltenham

Email: caf.bookings@nhs.net *Fax No: 01242 535 919*

Examination requested **CT** ☐ **MRI** ☐	*Ultrasound (Non Obstetric)* ☒ *N/A AT COBALT*

Body Area – *Please circle*

CT: Head ☐ Chest ☐ Abdomen ☐ Pelvis ☐

MRI: Head ☐ Chest ☐ Abdomen ☐ Pelvis ☐ Lumbar ☐ ***(Clinical criteria apply – see page 2)***

NHS NUMBER		TITLE		MALE ☐	FEMALE ☐
SURNAME		FIRST NAME			
ADDRESS					
POSTCODE		DATE OF BIRTH			
PATIENT HOME TEL NO:		PATIENT MOBILE NO:			

Clinical findings, previous ops, questions to be answered:

Weight: (Kg)	Other considerations: (e.g. Language, Interpreter, Hearing, Details of relative to contact if patient does not have capacity)		
REFERRER'S NAME IN CAPITALS		Date of request	
SURGERY NAME AND ADDRESS		Practice Code	
		Referrers signature (Electronic signature acceptable)	
SURGERY PHONE		SURGERY FAX	
COPY RESULTS TO			

FOR MRI CONTRA-INDICATIONS: ***Signing form implies NONE of the below apply: -***
Cardiac pacemaker; metal in orbit; internal hearing device; intracranial vessel clip; valve replacement; metallic foreign body; claustrophobia

FOR CT & MRI: is there a possibility the patient may be pregnant?	YES ☐	NO ☐

FOR MRI and CT:	Recent creatinine: YES ☐ NO ☐ ***If the patient has any renal impairment it is essential that they have had a recent creatinine***	Date of creatinine: Result:

Does the patient have any of the following? Please mark (circle or tick) where applicable.

a) Previous reaction to IV contrast	YES ☐	NO ☐
b) Allergies	YES ☐	NO ☐
c) Diabetic	YES ☐	NO ☐
If yes, is the patient taking Metformin?	YES ☐	NO ☐
d) Has the patient had any imaging in the last 2 years?	YES ☐	NO ☐
If yes, where did the imaging take place?		

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Fax No: 01242 535 919

NHS NUMBER		GENDER	MALE ☐	FEMALE ☐
SURNAME		FIRST NAME		
POSTCODE		DATE OF BIRTH		

MRI LUMBAR SPINE REFERRALS ONLY – THE FOLLOWING SECTION MUST ALSO BE COMPLETED

Reason for referral

Referrer must answer either 1, 2 or 3

1. Back pain and or leg pain with potentially serious (red flag) features e.g. major risk factors for cancer, risk factors for spinal infection

Must answer yes to at least one of the below for referral to meet clinical criteria

Less than 20 or over 50	YES ☐	NO ☐
Previous relevant malignancy	YES ☐	NO ☐
Systemic illness	YES ☐	NO ☐
HIV	YES ☐	NO ☐
Weight loss	YES ☐	NO ☐
Night pain	YES ☐	NO ☐
Spinal malignancy, infection or fracture is suspected**	YES ☐	NO ☐

NB if fracture is suspected, a plain XR film should be done prior to any MRI, which should only be done if recommended by a Radiologist. In these cases it may be more appropriate to consider referring the patient for review in the fracture clinic

NB If acute trauma, suspected Cauda equina Syndrome or acute cord compression refer patient to A&E

2. Acute sciatica (Leg pain in a nerve root distribution) without potentially serious features (red flags)

Must answer yes to both for the referral to meet the clinical criteria

Face to face contact with a relevant therapist e.g. Physiotherapist, Osteopath, Chiropractor for a **minimum of 6 weeks**	YES ☐	NO ☐
Patient has received a course of clinically appropriate analgesia for a **minimum of 6 weeks**	YES ☐	NO ☐

3. Lumbar back pain acute or chronic with no clinical or serological indicators of infection or neoplasia (i.e., no red flags)

If ticked; referral does NOT meet the clinical criteria

YES ☐