|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ***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](mailto:CAF.bookings@nhs.net) | | | | | | | | | | | | | | | | |
| Examination requested - tick CT or MRI | | | *Ultrasound (Non Obstetric)  N/A AT COBALT* | | | | | | | | **CT** | | | | **MRI** | |
| Body Area – *Please circle*  **→** CT: Head - Chest - Abdomen - Pelvis  **→** MRI: Head/Brain *(incl. dizzy pathway)* - Chest - Abdomen - Pelvis - Lumbar*(linked to back pathway)* | | | | | | | | | | | | | | | | |
| NHS NUMBER | |  | | | | | GENDER | | | 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) | | | | | | | | | | | | | | | |
| 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 MRI LUMBAR SPINE: *Referral does not meet the clinical criteria for direct access MRI if any of the below applies*. *Signing form implies patient has NONE: -***  **1) Chronic back pain (>6weeks) without potentially serious features; 2) Acute back pain (≤6 weeks) without potentially serious features; 3) Suspected osteoporotic collapse; 4) Suspected osteomyelitis; 5) Symptoms are suggestive of cauda equina syndrome** | | | | | | | | | | | | | | | | |
| **FOR CT & MRI:** is there a possibility the patient may be pregnant? | | | | | | YES | | | | | | NO | | | | |
| **FOR CT WITH**  **IV CONTRAST :** | Recent eGFR: YES  NO | | | | | Date of eGFR:  Result: | | | | | | | | | | |
| Does the patient have any of the following? Please mark (circle or tick) where applicable. | | | | | | | | | | | | | | | | |
| 1. Previous reaction to IV contrast | | | | | | | | YES | | | | | NO | | | |
| 1. Allergies | | | | | | | | YES | | | | | NO | | | |
| 1. Diabetic | | | | | | | | YES | | | | | NO | | | |
| If yes, is the patient taking Metformin? | | | | | | | | YES | | | | | NO | | | |
| 1. Has the patient had any imaging in the last 2 years? | | | | | | | | YES | | | | | NO | | | |
| If yes, where did the imaging take place? | | | | | | | |  | | | | | | | | |