Cobalt Imaging Centre Referral Form

1.5 and 3.0 Tesla MRI, CT, Ultrasound and X-ray

T: 01242 535910 E: bookings@cobalthealth.co.uk

PET/CT referrals must be submitted on an alternative form, please contact us for a copy

Patient Name:

Date of Birth: **Sex:** F

Home phone number: _____

Mobile phone number: _____

Email address: _____

Insured / Self funding / NHS Invoiced Insured

Insurance Company: _____

Authorisation Number: _____

Address:

_____

_____

_____

_____

_____ **Postcode:** _____

NHS Number:

Area to be examined:

Type: **MRI / CT / Ultrasound / X-ray**

Relevant clinical summary:

Weight kg	**Claustrophobia:** N	**Diabetic** N	**Asthmatic** N
Pregnant N	**Date of last menstrual cycle** _____		

Previous relevant imaging, including type, location and date:

Referrer Details

Referrer Name:
(please print)
Specialty: (i.e. GP/Consultant)

I would like images on:
MyVue (online) ■ **IEP** ☐

Secure email address (required):

Postal address:

Referrers Declaration: ***Please sign below to indicate that you excluded the following MRI contraindications:*** Cardiac Pacemaker, Internal Cardiac Defibrillator, Intracranial Vessel Clips, Internal Hearing Devices - ***MRI examination is not possible.*** Metal fragments in the eye - ***An orbital X-ray may be required, please contact us prior to referral.***

Signed: **Date:**

Prefer to make your referral online? Visit *www.cobalthealth.co.uk/referrals*

Cobalt
Medical Charity
Diagnosis • Research • Education