# YORK TEACHING HOSPITAL NHS TRUST

# Primary Care SPINAL MRI Scan Referral

Authorised referrers **ONLY** must complete **ALL** non “Radiology only” sections on this page

Forms completed by a third party will be returned

WARNING - Incomplete requests could delay this examination or result in an incomplete investigation

|  |  |
| --- | --- |
| **Patient Information**  **Patient Name**: <Patient Name>  **NHS Number:** <NHS number>  **DOB**: <Date of birth>  **Gender:** <Gender>  **Address:**<Patient Address>  **Telephone Number**: <Patient Contact Details>  **Mobile Number:** <Patient Contact Details> | Patients need to be able to reliably answer safety questions prior to MRI (about metal foreign bodies and implants etc). If their cognition is impaired and they may not be able to do this extra time is allowed for plain film testing prior to MRI so… ***Is the patient able to independently answer MRI Safety Screening questions*** Yes  No  Implanted device which may be a contraindication to MRI? Yes  No  If so, what are they? |
| **Examination requested** [**(see CCG guidelines)**](http://www.valeofyorkccg.nhs.uk/rss/index.php?id=radiology)**:**    Patient is on a fast track pathway?  Yes  No |
| **Clinical details and diagnosis:**    Duration of Symptoms  Failure of conservative management?  Yes  No  **Do not order an outpatient MRI if symptoms of malignant compression -** [**contact MSCC coordinator**](https://www.valeofyorkccg.nhs.uk/rss/index.php?id=cancer)  **symptoms of cauda equina -** [**send patient to A&E**](https://www.valeofyorkccg.nhs.uk/rss/data/uploads/radiology/sumary-guidance-for-imaging-and-management-of-low-back-pain-27619.pdf) | **Is the patient known to have severe renal impairment (defined eGFR <30ml/min/m2)?** (Mandatory) Yes  No  If **yes EITHER:** provide eGFR (<2 months old) **\*eGFR**: <Numerics> Date **OR:**  tick box  to indicate eGFR being ordered  Requests may not be processed until results are available to us. |
| Severe radicular pain for > 6 weeks MRI ONLY AVAILABLE if assessed by a physiotherapist **and** not improving.  Confirm Physio assessment undertaken |
| **Disability?** Yes  Hearing  Visual  Learning  **Please describe mobility:**  Walking  Trolley  Chair  Bed  Hoist  O2  **Interpreter needed? Yes  No**  **Which language?**  **Weight:** <Latest Weight> |
| Radicular symptoms causing motor symptoms/signs |
| Suspected infectious or malignant cause of pain |
| Assessment of suspected recent osteoporotic fracture causing severe back pain |
| Suspected spinal stenosis causing symptoms of spinal claudication **AND** patient would consider surgery |
| Suspected myelopathy in the presence of other potentially serious symptoms or signs.  Tick those that apply:  State clinical features |
| This request been discussed with a consultant? Who?  This test has been suggested by a specialist team Which one? / Who?  **If suspected rheumatological disease seek specialist view on need for MRI before ordering** | |
| Referring Clinician Requests only accepted from Trust approved referrers - Ionising Radiation (Medical Exposure) Regulations 2000  **GP Name** : or freetext  **GP Practice**: BXXXXX – St Elsewhere, 14 High Street, York LEEDS YOX XXX  Tel: XXXXXXX – Fax: XXXXXXX – Email: XXXXX@nhs.net  **GMC / NMR / CSP Number**:       (compulsory for email requests)  **Date of referral**: <Today's date> | |
| ***For Radiology Use Only*** In ☐ Out ☐ List ☐  Authorised by: **U**rgent ☐ **S**oon ☐ **R**outine ☐  Practitioner:  Operator: Scan type:  Comments:  IV Contrast: Y ☐ N ☐ Oral Contrast: Y ☐ N ☐  Radiology appointment date & time: | |