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| Barnet Clinical Commissioning Group**InHealth Logo (Smaller).jpgNEL ICB Open MRI Referral Form**(B**ariatric/Claustrophobic Service)** |  |

 **Please note: this service does not accept urgent referrals. All referrals are booked in and treated as routine.**

**Please note – we are unable to accept referrals for patients under 18 years of age**

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| **Symptoms indicative of / suspected Cauda Equina?** **Yes** [ ]  **No** [ ]  Please note – we are unable to accept referrals where cauda equina syndrome is the working diagnosis of or suspected by the referrer or in patients where the symptoms are indicative of it. Please redirect any referral to the appropriate provision |

**PLEASE NOTE**

**PATIENTS WEIGHING OVER 24 stone / 152kg will need to provide waist measurement and shoulder to shoulder width (please add below with height/weight)**

**WE ARE UNABLE TO ACCEPT REFERRALS FOR THE FOLLWING MRI SCANS:**

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| **CARDIAC** |  |  | **GYNAE PELVIS** |  |  |
| **SMALL BOWEL STUDY** |  | **JAW** |  |  |  |
| **LIVER / PANCREAS** |  | **ARTHROGRAMS OF ANY JOINT** |
| **KIDNEYS** |  |  | **TEMPERO MADIBULAR JOINTS** |
| **CHEST WALL** |  |  | **ADVANCED BRAIN IMAGING** |
| **STERNUM** |  |  | **PROCTOGRAMS** |  |
| **PROSTATE** |  |  | **TEMPERO MADIBULAR JOINTS** |
| **RECTUM** |  |  | **CSF FLOW STUDY** |  |
| **MRCP** |  |  |  |  |  |  |  |
| **LUMBO-SACRAL PLEXUS** |  |  |  |  |
| **BREAST** |  |  |  |  |  |  |
| **CONTRAST ANGIOGRAPHY OF THE VESSELS** |  |  |  |

**Main reason for referral: Bariatric** [ ]  **Claustrophobic** [ ]

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| **Please ensure these criteria are considered before referring a patient**1. Has the patient attempted a scan in a conventional scanner?
2. Patient is over 21st (135kg) please indicate height and weight below? (open scanner table limit 35 stone)
3. Have other options been considered for Claustrophobic Patients?

**(patient must meet these 4 criteria in order to be referred)*** 1. patients failing to tolerate a standard MRI have been offered a standard MRI with oral sedation
	2. The requested scan is for the head/ neck/ thorax/chest/abdomen (Any scans below the hips/lumber spine can be done in a conventional MRI scanner)
	3. The width measurement of the patient at their widest point is greater than 27 inches/ 70cm
	4. The applicant can confirm that alternative diagnostic tools such as X-ray or ultrasound are inappropriate for securing differential diagnosis.
1. Is the patient able to travel independently to an Open MRI Scanner?
 | [ ] Yes[ ] No[ ] Yes[ ] No[ ] Yes[ ] No[ ] Yes[ ] No[ ] Yes[ ] No[ ] Yes[ ] No[ ] Yes[ ] No |
| **Please include any information that will assist with the management of this patient** |
| **PATIENT** | **REFERRER** |
| NHS Number |  | Name |  |
| Forename |  | GMC/HPC/NMC No |  |
| Surname |  | Address |  |
| Address |  |
| Date of Birth (Over 18 only) |  | Referring CCG Code |  |
| Telephone (Home) |  | Referring Practice Code |  |
| Telephone (Work) |  | Telephone No. (**for urgent clinical findings)** |  |
| Telephone (Mobile) |  | Fax No. |  |
| E-mail Address |  | NHS.net mail only |  |
| Gender | Male [ ]  Female [ ]  | If interpreter required, language:  |
| Physical/Communication difficulties (specify if any):  | Height:Shoulder Width: | Weight:Waist Measurement: |
| Ethnicity |
| **PRESENTING COMPLAINT & PROVISIONAL DIAGNOSIS**Please provide as much relevant clinical information as possible to assist with the interpretation of the referral and images.  |
| **Investigation(s) Required:** please indicate which side of body and body part where appropriate. |
| What is the patients’ presenting complaint? |
| How long has the complaint been persisting? |
| What treatment/management of the condition has been provided? |
| What is the clinical question you require us to answer? |
| Please tick box if this scan is related to recent (within 5 years) spinal or neurosurgery [ ]  |
| **All referrers must complete the following MRI safety questions:**1. Does the patient have any implanted metallic foreign devices? (e.g. cardiac pacemaker, artificial heart valve, cerebral aneurysm clips, cochlear implant etc)
2. Is the patient known to have metallic fragments in their eyes?

Date of Referral  | **Yes** **[ ]  No** **[ ]** **Yes [ ]  No [ ]**  |
| Please e-mail this form to Inhealth Upright Open MRI E-mail: inl.london.uprightmri@nhs.net**Tel:** 020 7637 2888   | **www.inhealthgroup.com****Version: June 2025** |