**NCL Approval and Application Form for Open MRI**

|  |
| --- |
| Section 1 - Information Governance Statement  This application form and any other supporting information supplied may be shared with the CCG or other trusted organisations legitimately acting on behalf of the CGG. Personal information may be retained only for the purposes of this and, in some cases, may be used for invoicing and payment reconciliation. Anonymised information may also be shared as part of CCG reporting processes. |
| PLEASE SIGN BELOW TO INDICATE THAT YOU:  Have discussed the information governance statement above with your patient and that they give their consent for information about their case to be used to process their application in accordance with the provisions of that statement.  **Applicant’s signature**  Signed by: ……………………………………………………………………… Date signed: ……………/……………/……………  Print name: …………………………………………………………………… GMC No: ……………………….………………………  All forms must be signed by the NHS Practitioner (unsigned forms will not be accepted). |
| This form should be sent from an **nhs.net secure email** account to: **polce.camden@nhs.net**  Please call **020 3182 1774** if you need support to complete this form. |

|  |  |
| --- | --- |
| **Quality of imaging**  Please tick to confirm that you have explained to the patient that an open MRI provides a poorer quality image compared to standard MRI and therefore subtle abnormalities are likely to be missed. Only tick if the patient is fully aware prior to requesting a MRI. | Please tick to confirm  🞏 |

|  |  |
| --- | --- |
| **Only complete the rest of the form below if you have answered ‘yes’ to all questions below in either section 2a OR 2b, as for patients to qualify for open MRI they must either be claustrophobic or have a width measurement at their widest point greater than 27 inches / 70cm** | |
| **Section 2a – Does the patient meet the Open MRI interim criteria?**  The expected pathway for patients with claustrophobia is that there is documented evidence of the criteria below. Please confirm yes or no that these criteria have been met | |
| 1. Patients failing to tolerate a standard MRI have been offered a standard MRI with oral sedation | 🞏 Yes, please provide details below    🞏 No |
| 1. The requested scan is for the head/ neck/ thorax/chest/abdomen    1. (Any scans below the hips/lumber spine can be done in a conventional MRI scanner) | 🞏 Yes, please provide details below    🞏 No |
| 1. The applicant can confirm that alternative diagnostic tools such as Xray or ultrasound are inappropriate for securing differential diagnosis. | 🞏 Yes, please provide details below    🞏 No |

|  |  |
| --- | --- |
| **Section 2b – Does the patient meet the Open MRI interim criteria?**  The expected pathway for patients with a high waist circumference of 27 inches / 70cm or more. Please confirm yes or no that these criteria have been met | |
| 1. 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) | 🞏 Yes, please provide details below    🞏 No |
| 1. The (width) measurement of the patient at their widest point is greater than **27 inches / 70cm** | 🞏 Yes, please provide details below  🞏 No |
| 1. The applicant can confirm that alternative diagnostic tools such as Xray or ultrasound are inappropriate for securing differential diagnosis. | 🞏 Yes, please provide details below   🞏 No |

|  |  |  |
| --- | --- | --- |
| **Section 3 - Application form to request funding for open MRI (only complete if sections 1 and 2 complete)** | | |
| **1. Patient details** | **NHS number:** |  |
|  | **Name / Initials:** |  |
| **Date of birth:** |  |
| **Address:** |  |
| **Contact / mobile number:** |  |
| **2. GP details** | **Practice name:** |  |
|  | **Registered GP name:** |  |
| **Postcode of registered GP:** |  |
| **CCG:** |  |
| 1. **Requesting clinician if different to GP** | **Name:** |  |
|  | **Designation:** |  |
| **Trust:** |  |

|  |  |
| --- | --- |
| **Section 4. Clinical information** – To be completed by the referrer | |
| What is the clinical questions you are asking and how will help you in your management of the patient? |  |
| If any other investigations have been carried out, in relation to this condition please attach the results. |  |
| Please provide any other relevant clinical information: |  |
| **For patients who are claustrophobic:** | |
| **5(a)** If patient has had previous conventional MRI, please explain where this was and reason why this cannot be done again. |  |
| **5(b)** Please indicate any problems that occurred in relation to these investigations: |  |
| **5(c)** Please provide details of where and when a closed MRI under oral sedation has been attempted. What sedation was used? |  |

**For patients who are obese**

The average conventional MRI scanner is able to accommodate the following:

|  |  |  |
| --- | --- | --- |
| Conventional 1.5T Scanners  (Bore diameter 23.5” – 60cm) Please ensure patients are able to fit into the scanner | 21 stone | 135kg |

Patients who are too large to fit within a conventional MRI scanner should be referred by a secondary care clinician to the bariatric MRI service at Barts Health.

|  |  |
| --- | --- |
| **Please tick the provider as appropriate:** | 🞏 Inhealth - Croydon  🞏 Barts Health |