**Please note – the service is for patients who are 19 years and over.**

**For MSK, please refer to Locomotor in the first instance. They have short waits and can refer for MRI if required.**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PATIENT** | | | **REFERRER** | | | | | |
| NHS Number |  | | Name | | |  | | |
| Forename |  | | GMC/HPC/NMC No | | |  | | |
| Surname |  | | Address | | |  | | |
| Address |  | |
| Date of Birth |  | | 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: | | | | | |
| Height: | | Weight: | Ethnicity: | Physical/Communication difficulties (specify if any): | | | | |
| PRESENTING COMPLAINT & PROVISIONAL DIAGNOSIS - Please provide as much relevant clinical information as possible to assist with the interpretation of the referral and images. Please attach any x-ray/ultrasound scans that have been done previously to assist with diagnosis. | | | | | | | | |
| Please tick box if this scan is related to recent (within 5 years) spinal or neurosurgery | | | | | | | | |
| **Investigation(s) Required:** tick investigation required; please indicate which side of body and body part where appropriate. | | | | | | | | |
| **CLINICAL CONDITIONS** | | | | | **MRI REQUEST TIMESCALES** | | |  |
| **Lumbar spine (lower back)**:  Sciatica With Soft Neurological Signs  (e.g. numbness, paraesthesia, loss of reflex) | | | | | Consider locomotor (physio) referral  MRI and / or consultant referral (as appropriate) | | |  |
| Sciatica Without Neurological Signs  ***NOTE:*** Red Flags includingCauda Equina, H/O weakness / wasting, legs giving way, Bowel / Bladder disturbance, perineal / perianal sensory disturbance, loss of anal tone, foot drop, weight loss, cancer, TB, infection – Urgent Referral via A & E or Spinal Surgical Route | | | | | Please refer for locomotor (physio) in the first instance  6-8 weeks of physio before considering an MRI | | |
| **Cervical spine:**  Pain with neurological signs  (e.g. loss of grip / dropping objects, brachalgia, myelopathic signs) | | | | | MRI and / or consultant referral (as appropriate) | | |  |
| Persistent pain with neurological symptoms after conservative treatment, including physiotherapy has been tried. | | | | | MRI after 6-8 weeks physio | | |
| **Knee:**  The local knee pathway only recommends knee MRI for patients under 40 who have suffered a high impact trauma. | | | | | Refer for a plain film weight bearing x-ray and then locomotor (physio) before MRI. | | | **L**  **R** |
| **Head:**  Not indicated in patients with primary headache disorders: migraine, tension, cluster and medication overuse. | | | | | - Avoid in primary headache solely for reassurance  - Significantly more likely to uncover incidental findings.  - Studies suggest that reassurance for patients only lasts 10 months | | |  |
| Indicated in headache  causing patient to wake from sleep  associated and unexplained neurological symptoms  headache with vomiting and papilloedema  headache with seizures in those not known to be epileptic  increasing frequency and severity of the headache | | | | | For many of these indications urgent referral or specialist advice may be more appropriate | | |
| **Shoulder** | | | | | Refer for a plain film x-ray- if suspected fracture/cancer or stiff shoulder- and then locomotor (physio) before MRI. | | | **L**  **R** |
| **Other:** (State body part and body side) | | | | |  | | |  |
| **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 post, fax or e-mail this form to the InHealth Patient Referral Centre**  **Sandbrook House, Sandbrook Way, Rochdale, OL11 1RY**  **Tel: 0333 202 0297 E-mail: london.prc@nhs.net** | | | | | | | |  |
| **www.inhealth.com**  **Version: March 2019** | | | | | | | |  |