Request Form: Diagnostic Imaging

UPMC | SSC
SPORTS SURGERY CLINIC

Please complete all sections of this request form. Incorrectly completed forms will be returned.

Radiology tel: 01 526 2060 / radiologySSC@upmc.ie / fax: 01 526 2061

Name:		Gender: M	F
Address:		Date of Birth:	/ /
		Finance: Club affiliation:	Insurance: Self Pay:
SSC No.:		Insurance Type/No:	
Tel:	Mobile:	Email:	

REFERRAL INFORMATION

MRI ☐ CT ☐ X-ray ☐ US ☐ DEXA ☐ Interventional ☐

Examination Requested: (e.g. 'MRI Right Mandible' – side must be written in full)

Clinical Indication (Justification for referral):

Provisional diagnosis:

MRI Safety Questions					
Pacemaker/Cardiac defibrillator (ICD):	Yes ☐	No ☐	Ever had any metal fragments in their eyes or skin?	Yes ☐	No ☐
Any metallic device or implant in the body?	Yes ☐	No ☐	For contrast – Is this patient attending a Nephrologist?	Yes ☐	No ☐

REFERRING CLINICIANS DETAILS	
Name:	Hospital (if applicable):
Telephone/Bleep:	Address:
Fax:	
Email:	IMC number:
Signature:	Date:

Office Use

Date & time Slot Held: Amount Quoted: € Pregnant: Yes ☐ No ☐ Special requirements: Any other info given

Patient advised to bring images: Yes ☐ No ☐ N/A ☐ | Blood thinners: Yes ☐ No ☐ | Patient advised re driving: Yes ☐ No ☐