	Lilongwe Institute of Orthopaedics and Neurosurgery **Department of Radiology** **MRI REQUEST FORM**

SEE OTHER SIDE FOR MRI CHECKLIST!

	Date of Requisition		
	Surname	First name	
Patient name			
Date Of Birth		Sex	

Private patient ☐ Non-paying patient ☐

Referral ward/department	
Referring doctor (PLEASE PRINT)	
Phone number	

Requested examination	
Requested time of examination	☐ Routine ☐ Urgent

Clinical findings and short history:

Provisional diagnosis:

IF CONTRAST:

Previously known severe contrast media reaction:	Yes ☐	No ☐
Known kidney failure	Yes ☐	No ☐
Biochemistry results:		
Creatinine:		mg/dl
Urea:		mg/dl

Signature: _____

For the radiology department:

Initials:

	Lilongwe Institute of Orthopaedics and Neurosurgery **Department of Radiology** **MRI Checklist – all questions must be answered.**

Patients name (PRINT) _____**DoB** _____
Private patient ☐ Non-paying patient ☐

Referring physician (PRINT)_____

1. Do you have, or have you had:

- pacemaker?	Yes ☐	No ☐
- neurostimulator?	Yes ☐	No ☐
- insulin pump?	Yes ☐	No ☐
- hearing aid?	Yes ☐	No ☐
- aneurismal clip?	Yes ☐	No ☐
- intraorbital metals?	Yes ☐	No ☐

2. Have you undergone surgery:

- heart?	Yes ☐	No ☐
- head?	Yes ☐	No ☐
- eyes?	Yes ☐	No ☐
- ears?	Yes ☐	No ☐
- spine?	Yes ☐	No ☐
- any other surgery?	Yes ☐	No ☐

3. Do you have any items of metal in your body, previous procedures, gun shot or shrapnel injury? Yes ☐ No ☐

If yes, specify_____

4. Have you previously been operated in the area to be examined? Yes ☐ No ☐

If yes – what kind of operation? _____

5. For women: Are you pregnant? Yes ☐ No ☐

A strong magnetic field is used to perform the MRI examination.
Loose objects can not be taken into the MRI room.

In order to conduct the examination, we need information about your height and body weight:
Height: _____ cm Weight: _____kg

Date: _____ Patien't signature: _____

_____ _____

Referring physician's signature Radiographer's signature