

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	<input type="checkbox"/> Routine <input type="checkbox"/> Urgent

**Clinical findings and short history:**

--

**Provisional diagnosis:**

----------

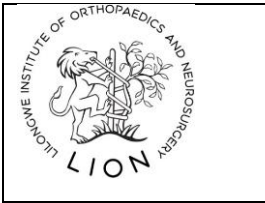
**IF CONTRAST:**

Previously known severe contrast media reaction:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Known kidney failure	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Biochemistry results:		
Creatinine:		mg/dl
Urea:		mg/dl

Signature: \_\_\_\_\_

**For the radiology department:**

          	<b>Initials:</b>  
--	--------------------------



**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