



**MR REFERRAL FORM**

Patient's Name: \_\_\_\_\_  
 Sex: \_\_\_\_\_ Age: \_\_\_\_\_ D.O.B.: \_\_\_\_\_  
 Referring Doctor: \_\_\_\_\_  
 Hospital: \_\_\_\_\_ Ward: \_\_\_\_\_

**MEDICAL HISTORY** (Please ✓ the appropriate)

- |   |   |
|---|---|
| <input type="checkbox"/> Pregnant                 | <input type="checkbox"/> Intravascular Stent  |
| <input type="checkbox"/> Heart Disease            | <input type="checkbox"/> Cardiac Pacemaker    |
| <input type="checkbox"/> Arrhythmia               | <input type="checkbox"/> Valvular Replacement |
| <input type="checkbox"/> Hypertension             | <input type="checkbox"/> Orthopaedic Implant  |
| <input type="checkbox"/> Diabetes Mellitus        | <input type="checkbox"/> Aneurysm Clips       |
| <input type="checkbox"/> Claustrophobia           | <input type="checkbox"/> Cochlear Implant     |
| <input type="checkbox"/> Previous Operation _____ |   |
| <input type="checkbox"/> None of the above        |   |

**ALLERGY HISTORY** (Please ✓ the appropriate)

- Asthma  
 Sea Food Allergy  
 Previous Contrast Allergy  
 Currently on Metformin  
 LMP \_\_\_\_\_  
 Drug Allergy \_\_\_\_\_  
 None of the above

**HEAD & NECK**

- Brain  
 Brain + MRA  
 Sella / Pituitary  
 Orbits  
 IAMs  
 Paranasal Sinuses  
 Face  
 Neck  
 Nasopharynx  
 Parotid / Submandibular Glands  
 TMJ

**MR ANGIOGRAPHY**

- Cerebral  
 Carotid / Vertebral  
 Pulmonary  
 Liver  
 Aorta  
 Upper / Lower Limbs  
 Whole Body

**SPINE**

- Cervical  
 Thoracic  
 Lumbar  
 Sacrum / Coccyx  
 Whole Spine

**BODY**

- Thorax / Mediastinum  
 Abdomen  
 \_\_\_\_\_  
 Pelvis  
 Whole Abdomen  
 Urogram  
 Cholangiogram (MRCP)  
 Breast  
 Prostate  
 Hypertension Package  
 Whole Body Screening

**OTHER** (Please specify the body region)

**CARDIAC**

- Anatomy and Function (LV)  
 Myocardial Viability  
 Stress and Rest Myocardial Perfusion  
 Full Package  
 Coronary CTA + Cardiac MR Full Package  
 (Please contact our staff for appointment)

**MUSCULOSKELETAL**

- |  |  |
|--|--|
| <input type="checkbox"/> Knee          | <input type="checkbox"/> Right           |
| <input type="checkbox"/> Ankle         | <input type="checkbox"/> Left            |
| <input type="checkbox"/> Shoulder      | <input type="checkbox"/> Both            |
| <input type="checkbox"/> Elbow         | <input type="checkbox"/> Hip             |
| <input type="checkbox"/> Wrist         | <input type="checkbox"/> Skeletal Survey |
| <input type="checkbox"/> Extremities   |  |
| <input type="checkbox"/> MR Arthrogram |  |

<b>Intravenous Contrast</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Optional (To be decided by Radiologist)
<b>Intraarticular Contrast</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Optional (To be decided by Radiologist)

Clinical Information -

Signature \_\_\_\_\_