KAMPALA MRI CENTRE

PATIENT NUMBER:

Balintuma road, Namirembe
Email:Info@kampalamricentre.com
Website: www.kampalamricentre.com

P.O Box 75636 Kampala
Tel: +256 (0) 790915767

REQUEST FOR MAGNETIC RESONANCE IMAGING (MRI)

PATIENT DETAILS:	REQUESTING DOCTOR DETAILS:
NAME:	NAME:
ADDRESS:	HOSPITAL
DATE OF BIRTH: AGE:	ADDRESS:
TEL:	TEL:
EMAIL:	EMAIL:

PREVIOUS IMAGING CT ☐ ULTRA SOUND ☐ X-RAY ☐ MRI ☐

CONTRAINDICATIONS:	YES	NO		YES	NO
PACEMAKER	☐	☐	ORTHOPEDIC IMPLANTS	☐	☐
ANEURYSM CLIPS	☐	☐	HEART VALVE PROSTHESIS	☐	☐
NEUROSTIMULATOR	☐	☐	COCHLEAR IMPLANT	☐	☐
METALLIC IOFB	☐	☐	SHUNTS OR STENTS	☐	☐
IMPLANTABLE PUMP	☐	☐	IS PATIENT PREGNANT	☐	☐
WAR INJURIES	☐	☐	TATOOS	☐	☐

CLARIFICATION ON THECONTRAINDICATIONS: .....

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CLINICAL HISTORY: .....

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MRI REQUESTED : .....

NON CONTRASTED CONTRASTED

LABORATORY FINDINGS:

SERUM UREA ☐ SERUM CREATINE ☐ OTHER (SPECIFY).....

NOTE: IT IS MANDATORY FOR ALL MRI WITH CONTRAST MEDIUM PATIENTS TO UNDERGO A RENAL FUNCTION TEST BEFORE BEING SCANNED.

DOCTORS SIGNATURE: ..... DATE.....