Pacific Radiology

MRI Radiology Request – University Research

For Researcher to Complete

Patient Information Mr/ Mrs/ Ms/ Miss M ☐ F ☐

Surname:_____ First Names:_____

DOB ___/___/____ NHI:_____

Address: _____ Mobile:_____

_____ Phone:_____

_____

Study Name:_____

Project Number:_____

Participant ID:

MRI Safety: Researcher must complete this section to indicate it is safe for the participant to undertake the requested MRI Examination

• Cardiac Pacemaker	Yes ☐	No ☐		• A History of Metal Within the Eye	Yes ☐	No ☐	
• Cochlea Implant	Yes ☐	No ☐		• Shrapnel within the Body	Yes ☐	No ☐	
• Intracranial Vessel Clips	Yes ☐	No ☐		• Claustrophobic	Yes ☐	No ☐	
• Artificial Heart Valve or Vascular Stent	Yes ☐	No ☐		• Pregnant	Yes ☐	No ☐	

Researcher Details:

Signed:_____

Name:_____

Date:___/___/_____ Copies of Results to:_____

Appointment Details: Date:___/___/____ Time:_____ Location:_____

RESEARCHER TO ADVISE PARTICIPANT TO ARRIVE 10 MINUTES BEFORE APPOINTMENT TIME