Referral to:

X-ray examination ☐ **Mammography** ☐ **MRI-scan** ☐ **Ultrasound** ☐

Patient:
Name:_____ CPR-number:_____

Address:_____ Phone:_____

Referring doctor:
Name:_____ Phone:_____ Address:_____

Information about the patient:

Patients height:_____ **weight:** _____**kg** **Pregnancy: Yes** ☐ **Week:**_____ **No** ☐

Examination, indication, region and side:

Checklist before MRI-scan must be completed:

1. Allergies: Yes ☐ Which type:_____ No ☐
2. Pacemaker, remaining pacemaker electrodes, ICD-units — Yes ☐ No ☐
   If yes, the patient can not get an MRI-scan at Capio CFR hospitals.
3. Metal implants or other kinds of metal from heart-, neuro- or other surgery — Yes ☐ No ☐
   Type:_____ Operation year_____ (Attach operation description)
   Heart valve prosthesis, neurostimulator, artificial sphincter or similar, ear implants (stapes prosthesis, intracochlear stimulator), clips, shunts, metal prosthesis, magnetic dental implants, insulin pump, vagusstimulator, baclofenpump, metal tracheostomy canyon, Port á cath., Swan Ganz cath., p-dialysis cath., bladder cath. w/ termocouple.
4. Other foreign objects — Yes ☐ No ☐
   E.g. metal fragments in eyes, shell fragments, piercings, medicine patches, tooth prosthesis/-braces
5. Does the patient have known kidney disease? — Yes ☐ No ☐
   If yes, eGFR:_____ml/min/1,73m2 (max. 7 days old)
   Outpatient patients with known kidney disease who needs MRI including contrast, will be asked to contact the referring physician in order to have a new eGFR before the MRI-scan.
6. Claustrophobia — Yes ☐ No ☐
   The referring physician may take care of soothing medication
   Indicate what preparation the patient is provided with_____(e.g. Alprazolam 0,5-1,0 mg).
   Calming medicine should be consumed approx. 45 minutes before the MRI-scan.
7. Is the referral sent by EDI-fact? — Yes ☐ No ☐

Medical person responsible for completing the verification form and obtaining informed consent:

Date:_____ Signature:_____ Readable name/stamp:_____

Reserved for the MRI-section: The checklist has been reviewed with the patient by:

Date:_____ Signature:_____