

**Referral to:**
**X-ray examination**     **Mammography**     **MRI-scan**     **Ultrasound** 
**Patient:**

Name: \_\_\_\_\_ CPR-number: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Referring doctor/insurance company/other:**

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 Capiro 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/1,73m<sup>2</sup> (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: \_\_\_\_\_

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