European Scanning Centre (Manchester) LLP Kingsley Hall 20 Bailey Lane Manchester M90 4AN
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REQUEST FORM

european scanning centre
A NEW ERA IN DISEASE PREVENTION AND DETECTION

Patient Name

Date of birth / /

Address

Email:

Tel:

Referrer Details

Tel: Fax:

How will the account be settled?

☐ Patient ☐ Doctor ☐ Insurance

☐ Other:

MRI INVESTIGATION REQUIRED

Please indicate region you require:

Contrast: ☐ Yes ☐ No

Scans will be performed in a supine position. Please tick here if you require a weight bearing position: ☐

Preferred Radiologist:

MRI WARNINGS: Does the patient have any contraindictions (e.g. aneurysm clips, cochlear implants, pacemaker, heart valves, metal in the eyes?) ☐ Yes ☐ No

ULTRASOUND REQUIRED

- ☐ Abdominal aorta
- ☐ Abdomen
- ☐ Pelvis
- ☐ Abdomen and Pelvis
- ☐ Joints & Steroid injection
- ☐ TVS Pelvis
- ☐ Renal tract
- ☐ Carotid Doppler
- ☐ Dynamic Gallbladder Prov.
- ☐ Prostate
- ☐ Neck
- ☐ Testes
- ☐ Thyroid gland
- ☐ Thyroid gland - FNA
- ☐ Other Ultrasound
- ☐ Leg veins for thrombosis
- ☐ Post micturition bladder
- ☐ Echocardiogram
- ☐ Musculoskeletal

Other scans

Clinical details

Allergies:

Dr Signature: