GALWAY CLINIC
WHAT MATTERS IS YOU
Member of the Blackrock Healthcare Group

Telephone Number: +35391785630
Fax: +35391785604
Email referrals: rad.referrals@galwayclinic.com
Email queries: radiology@galwayclinic.com

# RADIOLOGY SERVICES

## PATIENT DETAILS

Name: _____ Date of Birth: _____/_____/_____

Address: _____

Phone: _____ MRN: _____

Previous Patient in the Galway Clinic: Yes ☐ No ☐ Finance: Insurance ☐ Self Pay ☐

Insurance Type/No: _____

## REFERRAL INFORMATION

MRI ☐ CT ☐ X-Ray ☐ Ultrasound ☐ Mammography ☐

Interventional ☐ Nuclear Medicine ☐ PET CT ☐ Fluoroscopy ☐

Examination Requested: (e.g. MRI Brain)

Reason for Referral (Clinical Indication):

| CONTRAST RENAL RISK QUESTIONS | | |
|---|---|---|
| Any history of Renal Impairment | Yes ☐ | No ☐ |
| Is the patient over 65 years | Yes ☐ | No ☐ |
| Is the patient a Diabetic | Yes ☐ | No ☐ |
| Is the patient on Anti-hypertensives | Yes ☐ | No ☐ |
| ***If yes to any of these questions eGFR is required** | | |

| MRI POTENTIAL CONTRAINDICATIONS | | |
|---|---|---|
| Pacemaker/Heart Valve/Defibrillator (ICD) | Yes ☐ | No ☐ |
| Cerebral Aneurysm Clip | Yes ☐ | No ☐ |
| Eye/Ear implants | Yes ☐ | No ☐ |
| Neurostimulators | Yes ☐ | No ☐ |
| Other metallic implants | Yes ☐ | No ☐ |

## REFERRING CLINICIANS DETAILS

| | |
|---|---|
| Name: | Hospital (if applicable): |
| Telephone: | Address: |
| Fax: | |
| Email: | GP: ☐ Consultant: ☐ Other: ☐ |
| **Signature:** | Date: |

Please complete all sections of this referral form, incomplete referrals will be returned.

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