Doughiska, Galway, H91HHTO
rad.referrals.Galway@blackrockhealth.com
blackrockhealth.com
1800 123450

BLACKROCK HEALTH
GALWAY CLINIC

RADIOLOGY SERVICES

PATIENT DETAILS

Name:_____ Date of Birth: _____/_____/_____
Address: _____
Phone: _____ MRN: _____
Previous Patient at Galway Clinic: Yes ❑ No ❑ Finance: Insurance ❑ Self Pay ❑
Patient Type: Day Case ❑ Insurance Type / No:_____
Out-Patient ❑ In-patient ❑
Date Requested: _____/_____/_____

REFERRAL INFORMATION

MRI ❑ CT ❑ X-Ray ❑ Ultrasound ❑ Mammography ❑
Interventional ❑ Nuclear Medicine ❑ PET CT ❑ Fluoroscopy ❑

EXAMINATION REQUESTED: (please clearly state anatomical area of interest e.g. MRI Brain)

REASON FOR REFERRAL (Clinical Indication):

CONTRAST RENAL RISK QUESTION: (MRI Potential Contraindications)

Any history of Renal Impairment	Yes ❑ No ❑	Pacemaker/Heart Valve/Defibrillator (ICD)	Yes ❑ No ❑
Is the patient over 65 years	Yes ❑ No ❑	Cerebral Aneurysm Clip	Yes ❑ No ❑
Is the patient a Diabetic	Yes ❑ No ❑	Eye/Ear implants	Yes ❑ No ❑
Is the patient on Anti-hypertensives	Yes ❑ No ❑	Neurostimulators	Yes ❑ No ❑
***If yes to any of these questions eGFR is required.**		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.