MR Imaging Referral Form

Please complete all sections and email to referrals@matai.org.nz

Patient Details

NHI	Phone No.	
Surname	Mobile No.	
First Name	Date of Birth	
Address	Gender	☐ M / F ☐
Address	Ethnicity	
City / Postcode	Medical Insurance	
GP Name	GP Location	

Referrer Details

Referring Doctor	
Location	
Contact Number	Referrer's Signature
EDI/ Fax/ Post Details	
NZMC No.	
ACC Referrer Provider Code	Referral Date

Report: Copies to Details	***Location of Practice***	***EDI/ Fax Details***
Name		

Result of an Accident?	☐ Yes / No ☐
ACC No.	
Date of Injury	

Examination Required:

Relevant Clinical History:

What is the clinical question?

REFERRERS MUST COMPLETE

(Please tick Y / N for each question that applies to the patient you are referring)

Cardiac Pacemaker, Defibrillators, or other Cardiac implants	☐ Y / N ☐	Injury by a metal object or foreign body (e.g. bullet, shrapnel)	☐ Y / N ☐
Aneurysm/ metal clips in the brain	☐ Y / N ☐	Injury to the eyes caused from a metal object or foreign body	☐ Y / N ☐
Any type of electronic, mechanical, or magnetic implant	☐ Y / N ☐	Suffer from Claustrophobia	☐ Y / N ☐

If yes, please provide details: