

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

Report: Copies to Details

Location of Practice

EDI/ Fax Details

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

Examination Required:

Relevant Clinical History:	
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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: