REFERRAL FORM

PATIENT NAME: _____

D.O.B: _____ DATE: _____

HOME: _____ CELL: _____

REFERRING PHYSICIAN: _____

PHYSICIAN PHONE: _____ EMAIL: _____

MRI REQUESTED:

Is Contrast Required YES ☐ NO ☐

If Yes Please tick behind to request a Creatinine blood test

1) _____

2) _____

3) _____

CLINICAL HISTORY: _____

_____

_____

- Does the Patient have a PPM or ICD? _____
- Does the Patient have ANY implants or Devices? _____

PREVIOUS SCANS

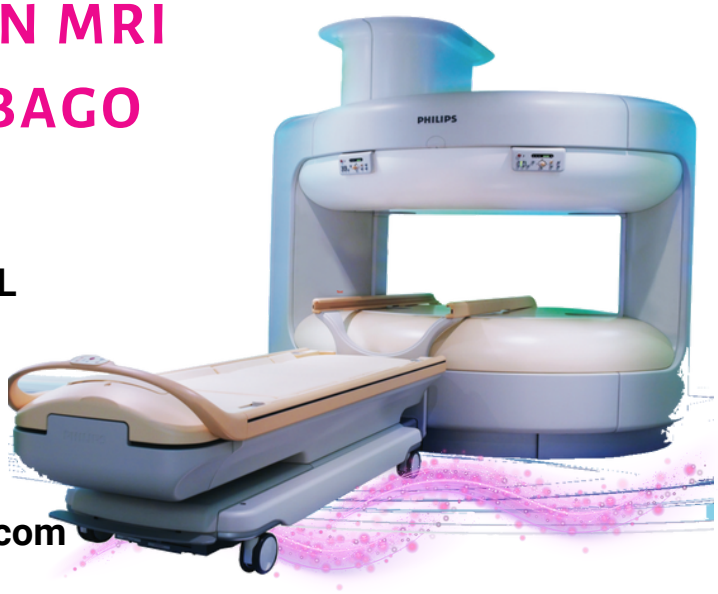
Please ask the patient to bring any previous X-ray, Ultrasound, CT and Mri - CD, flash-drive and reports of the area being scanned.

_____

Doctor's Signature & Stamp

Phone: 868-225-AMRI (2674)
ADDRESS: #4a Alexandra Street, St. Clair, Trinidad & Tobago
Email: patientcare@alexandramri.com Website: www.alexandramri.com

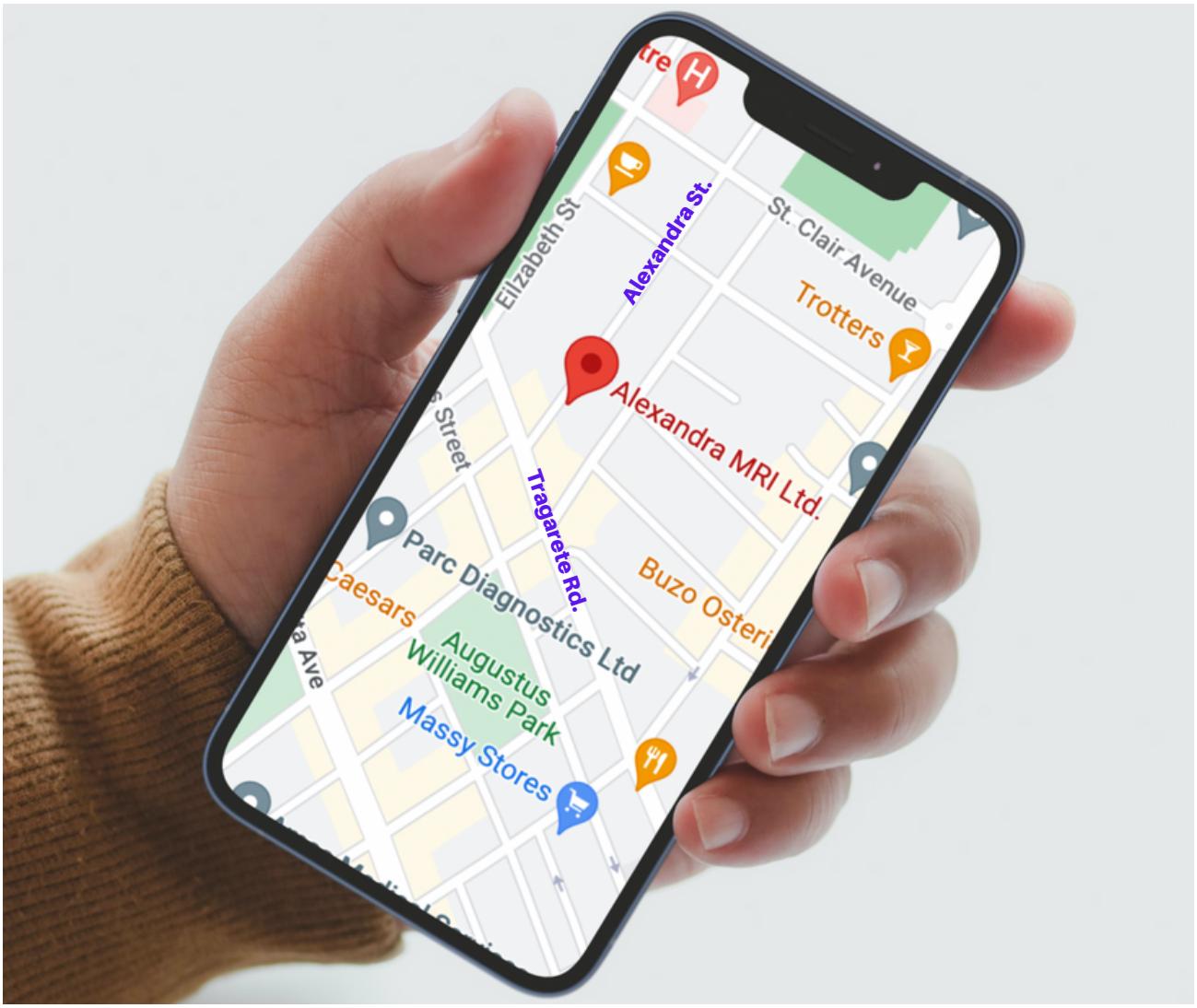
THE ONLY TRUE OPEN MRI IN TRINIDAD & TOBAGO



WHATSAPP YOUR REFERRAL TO 868-723-2674 (AMRI)

or

EMAIL YOUR REFERRAL TO patientcare@alexandramri.com



FIND US ON WAZE **OR** **GOOGLE MAPS**

Blood Test Request:

Creatinine ☐ **(Can be done at any Medical Lab)**