



Croydon Open MRI – Financial Authorisation

Date: ____/____/____

Patient funding:

Self Funded Insured NHS Funded

Patient Details

Mr / Mrs / Miss / Ms

Forename(s)

Surname.....

Date of Birth ____/____/____

NHS Number

Referrer Details

Dr / Mr / Mrs / Miss / Ms

Forename(s)

Surname

Hospital or trust

Contact Number

Email

Referral Details

Number of parts to be scanned **1 2 3 4 5 6**

Parts to be scanned, Please s specify

Reasons for an Open MRI scan: Claustrophobic Bariatric Other

Cost £ _____

Billing / Approval Information for NHS funded patients

Hospital, Trust, PCT, etc

Department

Address

PO/Reference

Contact Name

Contacts Position

Contact Number

Email

By signing below you are duly authorising InHealth to undertake the scan requested by the referring clinician.

Signature of Approving Contact

X _____

This authorisation form should accompany the referral request. Unfortunately, we are unable to scan NHS patients without prior authorisation.