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| **OPEN MRI (MAGNETIC RESONANCE IMAGING)** | | | | | | | | | | | |
| **PRIOR APPROVAL REQUIRED** | | | | | | | | | | | |
| **A Patient Information** | | | | | | | | | | | |
| **Name** |  | | | | | | | Male |  | Female |  |
| **Address**  **Post Code** |  | | | | | | | | | | |
| **Date of Birth** |  | | **NHS Number** | | | | |  | | | |
| **B Referrer’s Details (GP / Consultant / Clinician)** | | | | | | | | | | | |
| **Name** |  | | | | | | | **Patient requested referral** | | | |
| **Address**  **Post Code** |  | | | | | | | | | | |
| **Telephone** |  | | | **Email** | |  | | | | | |
| **GP Details (if not referrer)** | | | | | | | | | | | |
| **Name** |  | **Practice** | | | | |  | | | | |
| By submitting this form, you confirm that the information provided is, to the best of your knowledge, true and complete and that you have:   * Discussed all alternatives to this intervention with the patient * Had a conversation with the patient about the most significant benefits and risks of this intervention – Where appropriate * Informed the patient that this intervention is only funded where criteria are met, or exceptionality demonstrated * Checked that the patient is happy to receive postal correspondence concerning their application where appropriate, or clarified alternative needs * Checked that the patient understands spoken and written English, or clarified required needs   I understand that it is a legal requirement for fully informed consent to be obtained from the patient (or a legitimate representative of the patient) prior to disclosure of their personal details for the purpose of a panel / IFR team to decide whether this application will be accepted, and treatment funded. By submitting this form, I confirm that the patient / representative has been informed of the details that will be shared for the purpose and consent has been given. | | | | | | | | | | | |
| **Signed (referrer)** | | | | | **Date** | | | | | | |
| **Submission**  The completed form(s) should be sent electronically (from an *nhs.net* email address) in confidence with any other supporting documents to the appropriate email address: [BSWICB.EFR@nhs.net](mailto:BSWICB.EFR@nhs.net).  **To comply with information governance standards, emails containing identifiable patient data should only be sent securely, i.e., from an *nhs.net* account.** | | | | | | | | | | | |

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| **C Clinical Criteria - to be read in conjunction with the Open MRI Policy** |

bsw ICB will only fund Open MRI scanning of greater than 0.5t as an alternative to conventional MRI scanning if the patient cannot fit comfortably in a conventional scanner, or if the patient suffers from claustrophobia and oral prescription sedatives have not been effective (GPs are expected to support the prescription of sedatives in this situation).

**Patient’s BMI:**

|  |  |
| --- | --- |
| **Reason for Open MRI Request:** | |
| **CLINICAL CRITERIA** | |
| * Does the patient suffer from claustrophobia | Choose an item. |
| * Has an oral sedative been attempted in a conventional scanner?   (GPs are expected to support the prescription of sedatives in this situation) | Choose an item. |
| * Is the patient able to comfortably fit in a conventional scanner | Choose an item. |
| **Supporting information must be provided with the application. Please document the evidence you are enclosing to support this request:** | |
| ***Please be advised that consideration will not be given to any request for an Open MRI Scan if sedation has not been attempted in the first instance*** | |