**FUNDING REQUEST**

**Open MRI Scan**

The Hertfordshire and west Essex Evidence Based Intervention policy can be viewed at

<https://www.hweclinicalguidance.nhs.uk/clinical-policies>

**Please complete and return this form along with clinic letter/supporting evidence to:**

For west Essex patients [priorapproval.hweicb@nhs.net](mailto:priorapproval.hweicb@nhs.net) Tel: 01992 566150

For Hertfordshire patients [priorapproval.hweicb@nhs.net](mailto:priorapproval.hweicb@nhs.net) Tel: 01707 685354

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| --- | --- | --- |
| Patient consent | This application has been discussed with the patient and the patient consents to relevant information being shared with the ICB. | Please tick |

|  |  |
| --- | --- |
| Date form completed |  |
| Patient Name |  |
| DOB |  |
| NHS No. |  |
| Hospital No. |  |
| Patient’s GP and practice |  |

**Applicant Details**

|  |  |
| --- | --- |
| Applying Clinician’s Name |  |
| Job title |  |
| Contact details (including email) |  |
| Declaration | I declare that the information provided is, to the best of my knowledge, true and I am aware that this procedure may be subject to clinical audit. |

**Open MRI scanning is not routinely available and should be used only for the following indications where the criteria are met.**

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| 1. **Claustrophobia** | **YES** | **NO** |
| The purpose of the Open MRI is to assess for a potentially life-limiting or life-threatening condition. Please provide details. |  |  |
| MRI imaging is clinically indicated and other modalities e.g. CT scanning are not suitable. |  |  |
| What body part is this Open MRI request for? |  |  |
| The patient has failed to tolerate a standard MRI, after fears and concerns have been discussed with the radiology MDT. (Please provide outcome and recommendations from the radiology MDT)  **If yes**; Date of attempted scan……………………..  (Evidence of a radiologist’s discussion with the patient must be attached). |  |  |
| MRI under clinical supervision using oral sedation has been tried or is contraindicated for this referral/body part?  **If yes;** Type and dose of oral sedation: …………………………..  Date of attempted scan: …………………………..  **If no;**  Provide details of clinical contraindications to oral sedation,  or attach an explanatory clinic letter. |  |  |

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| --- | --- | --- |
| 1. **Patient Size** | **YES** | **NO** |
| The patient has been invited to attend the radiology department and has been formally assessed by them for suitability **AND** |  |  |
| The patient’s weight/BMI exceeds the maximum the MRI table can accommodate (please include height/weight/BMI in the clinic letter submitted) **OR** |  |  |
| The patient is unable to fit through a closed MRI scanner due to body size/shape. |  |  |

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| **For patients where the criteria are not met and it can be demonstrated that there is an exceptional healthcare need, an Exceptional Case Request Form can be submitted to the IFR team.** |