IMAGING REQUEST

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Follow up appointment with referring doctor:

Date: Time:

Name

Date of Birth

Address

Home

Mobile

Medicare No.

Examination Requested

Clinical Details

Referring Doctor Details

IMPORTANT: GP REFERRED CTCA'S - Please select compulsory "Cardiologist Consultation" below

◯ Cardiologist Consultation (refers patient for consult with a Heartscope Cardiologist prior to examination)

Doctor Signature

Date

MRI

Multiple GP referred under-16's and adult items rebated

Adult items:

◯ MRI Head 63551
Seizures, chronic headache

◯ MRI Cervical spine 63554
Radiculopathy

◯ MRI Cervical spine 63557
Trauma

◯ MRI Knee 63560
Acute trauma where ACL tear is suspected OR

◯ MRI Knee 63560
Acute trauma with inability to extend knee suggesting possibility of meniscal tear

MRI (+/-ORBITS+/-SKULL+/-CHEST X-RAY)

◯ Y ◯ N History of metalwork, grinding, welding?

◯ Y ◯ N Cardiac pacemaker?

◯ Y ◯ N Cardiac valve replacement?

◯ Y ◯ N Neurostimulator?

◯ Y ◯ N Brain aneurysm clip?

◯ Y ◯ N Ear implant?

◯ Y ◯ N Eye surgery or metal in eye?

CT Scanning

◯ Y ◯ N If diabetic, does treatment contain Metformin?

What is current renal function?

.....

Date of renal function: ...../ ...../20 ....

Doctor preference

◯ Film ◯ Electronic

◯ CD ◯ Other

Results

◯ Secure e-mail (via Healthlink)

◯ Phone report to .....

◯ Fax report to .....

◯ Return films/CD with patient

◯ Copies to:

◯ Patient ID verified (3 forms) ◯ Procedure explained Protocol: ◯ Marina

◯ Exam side & site verified ◯ Any risks explained to patient ◯ Radiologist

Radiologist _____ Imaging Technician _____

Are you, or could you be, pregnant? ◯ Y ◯ N ◯ N/A

The procedure and any risks have been explained to me and I consent to this

Patient / Guardian _____ Date _____

Appointments: Book online at marinaradiology.com.au/booknow or Call us on 1300 0 XRAYS (1300 097 297)

◯ Order more referral forms