

Monash Imaging Request

UR:

DOB:

M / F

Name:

Telephone (home):

Address:

Mobile:

Examination requested

- X-ray Nuclear Medicine
 Low Dose CT Interventional
 Ultrasound Fluoroscopy
 MRI Other

Clinical Details

Preferred date for imaging

Referring Doctor Details

Reports

- Images with patient

Result Phone number

Fax number

Copy of report to:

Does your patient require an interpreter? Yes No

If Yes, what language?

Signature: Date: Provider no.:

Coronary CT Angiography (At least one indication must be ticked for Medicare benefit)

- Patient with stable symptoms consistent with coronary ischaemia, at low to intermediate risk of coronary artery disease and would have been considered for coronary angiography
 For exclusion of coronary artery anomaly or fistula
 The patient will be undergoing non-coronary cardiac surgery

Precautions	Please specify	Any known allergies?		
Are extra infection precautions in place?		Patient pregnant? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NA		
Patient weight >150kg?		MRI Precautions (If Yes please contact MRI)		
Diabetic?		Cardiac Pacemaker / Defibrillator?	Yes	No
Hyperthyroidism?		Cerebral Aneurysm Clip?	Yes	No
Contrast studies Creatinine / eGFR:	Value: Date:	Cochlear Implant?	Yes	No

Monash Imaging Services Offered

	General X-Ray	Fluoroscopy	CT Scanning	Ultrasound (inc Doppler)	MRI	Angiography	Nuclear Medicine	PET	OPG	Mammography	DEXA
Monash Medical Centre - Clayton 246 Clayton Rd Clayton Ph: 9594 2200 Fax: 9594 6687	●	●	●	●	●	●	●		●		●
Monash Children's Hospital - Clayton 246 Clayton Rd Clayton Ph: 9594 2200 Fax: 8572 3234	●	●		●	●						
Moorabbin Hospital Monash Imaging 823-865 Centre Road Bentleigh East Ph: 9928 8828 Fax: 9928 8900	●	●	●	●	●		●	●		●	
Dandenong Hospital Monash Imaging 135 David Street Dandenong Ph: 9554 8175 Fax: 9554 8654 MRI Ph: 9554 8685 MRI Fax: 9554 8699	●	●	●	●	●	●	●		●		
Casey Hospital Monash Imaging 62-70 Kangan Drive Berwick Ph: 8768 1279 Fax: 8768 1966	●	●	●	●			●		●	●	

(insert patient label)

Monash Imaging Use Only

Intervention Team	<p>Time Out (Interventional studies only, checklist completed by scout nurse, interventionist and imaging technologist N.B. Performed immediately prior to commencement of intervention</p> <p>1. Correct patient verified? <input type="checkbox"/> Yes Safe to proceed, step (2)</p> <p>2. Procedure matches consent? <input type="checkbox"/> Yes Safe to proceed, step (3)</p> <p>3. Correct side/site identified and marked with indelible pen? <input type="checkbox"/> Yes N/A <input type="checkbox"/> Safe to proceed, step (4)</p> <p>4. L/R orientation confirmed on in-room monitor/image acquisition system <input type="checkbox"/> Yes N/A <input type="checkbox"/> Safe to proceed</p> <p>MIT (initial)</p> <p>Date: Time:</p> <p>Interventionist / fellow / registrar: (PRINT name): Signed:</p> <p>Nurse (PRINT name): Signed:</p> <p>MIT / SONO / (PRINT name): Signed:</p>		
	Radiologist	<p>Examination Details</p> <p>Protocol: Code: Dr Initials:</p> <p>Machine preference:</p> <p>I.V. Contrast required Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Oral Contrast required Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Recall details / sequences as required:</p>	
CT MIT/ NMT		CT Preparation Checklist	<p>3C's performed by Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Previous CT's checked by Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Recent eGFR Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Remaining oral contrast given by Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>IV cannula checked by Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>..... (Please initial)</p> <p style="text-align: center;">For Emergency or inpatients requiring IV contrast</p> <p>Does the patient have hyperthyroidism? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Suspected or diagnosed thyroid cancer? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Known allergies including iodine? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Is the patient taking metformin? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Does the patient have sickle cell anaemia? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Does the patient have myasthenia gravis? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Does the patient take Beta Blockers? Yes <input type="checkbox"/> No <input type="checkbox"/></p>
	Patient Name:	<p>Place IV contrast label here</p>	
UR:			
Height:			
Weight:			

Your doctor has recommended you use Monash Health.
 You may choose another provider but please discuss this with your doctor first.