MonashImaging
MonashHealth

Monash Children's Hospital

Monash Imaging MRI Prostate Request

UR: ..... DOB: ..... M / F

Name: ..... Telephone (home): .....

Address: ..... Mobile: .....

.....

.....

Examination requested (please tick which applies to your patient)

Item 63541 (*only payable once per patient every 12 months)

- ❑ a digital rectal examination is suspicious for prostate cancer
- ❑ under 70 years old; two PSA tests (prostate specific antigen) performed within 1-3 months; PSA both > 3.0 ng/ml; and free/total PSA ratio < 25%, or repeat PSA >5.5 ng/ml
- ❑ under 70 years old; risk based on family history is double the average risk (*1st degree relative with prostate cancer or BRCA1, BRCA2 mutation); two PSA tests performed within 1-3 months; both > 2.0 ng/ml, and free/total PSA ratio < 25%
- ❑ 70 years old and over; two PSA tests performed within 1-3 months; both > 5.5 ng/ml and free/total PSA ratio < 25%

Item 63543 (*only payable if patient has not had a diagnostic mpMRI and is on active surveillance. This item is not to be used for the purpose of treatment planning, or for monitoring after treatment)

- ❑ the patient is under active surveillance following confirmed diagnosis of prostate cancer by biopsy histopathology and the patient is NOT planning or undergoing treatment for prostate cancer

No item number

- ❑ MRI Prostate (no rebate) – does not meet eligible Medicare criteria

Clinical Details

Referring Doctor Details

Reports

❍ Images with patient

Result ❍ Phone number.....

❍ Fax number .....

❍ Copy of report to: .....

.....

.....

Does your patient require an interpeter? ❍ Yes ❍ No

If Yes, what language? .....

Signature: ..... *Date:* ..... *Provider no.:* .....

Precautions	Please specify	Any known allergies?		
Are extra infection precautions in place?		Patient pregnant? ❑ Y ❑ N ❑ 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

Time Out (Interventional studies only, checklist completed by scout nurse, interventionist and imaging technologist

N.B. Performed immediately prior to commencement of intervention

1. Correct patient verified? ☐ Yes Safe to proceed, step (2)
2. Procedure matches consent? ☐ Yes Safe to proceed, step (3)
3. Correct side/site identified and marked with indelible pen? ☐ Yes N/A ☐ Safe to proceed, step (4)
4. L/R orientation confirmed on in-room monitor/image acquisition system ☐ Yes N/A ☐ Safe to proceed

MIT (initial) .....

Date: ..... Time: .....

Interventionist / fellow / registrar: (PRINT name): ..... Signed: .....

Nurse (PRINT name): ..... Signed: .....

MIT / SONO / (PRINT name): ..... Signed: .....

Radiologist

Examination Details

Protocol:

Code: ..... Dr Initials: .....

Machine preference: .....

I.V. Contrast required Yes ☐ No ☐

Oral Contrast required Yes ☐ No ☐

Recall details / sequences as required:

CT MIT/ NMT

CT Preparation Checklist

Patient Name: .....

UR: .....

Height: .....

Weight: .....

Place IV contrast label here

3C's performed by ..... Yes ☐ No ☐

Previous CT's checked by Yes ☐ No ☐

Recent eGFR Yes ☐ No ☐

Remaining oral contrast given by Yes ☐ No ☐

IV cannula checked by Yes ☐ No ☐

..... (Please initial)

For Emergency or inpatients requiring IV contrast

Does the patient have hyperthyroidism? Yes ☐ No ☐

Suspected or diagnosed thyroid cancer? Yes ☐ No ☐

Known allergies including iodine? Yes ☐ No ☐

Is the patient taking metformin? Yes ☐ No ☐

Does the patient have sickle cell anaemia? Yes ☐ No ☐

Does the patient have myasthenia gravis? Yes ☐ No ☐

Does the patient take Beta Blockers? Yes ☐ No ☐

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