

Unit Record Number: _____
 Surname: _____
 Given Name: _____
 D.O.B: _____ Age: _____ Sex: _____
 Address: _____



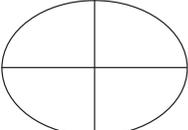
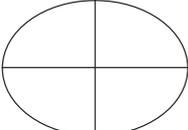
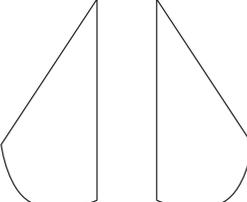
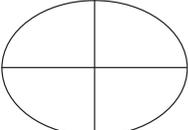
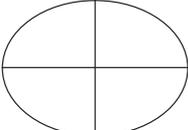
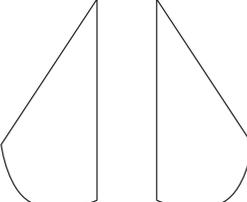
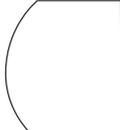
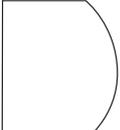
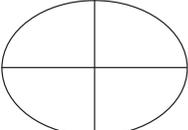
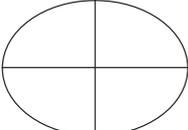
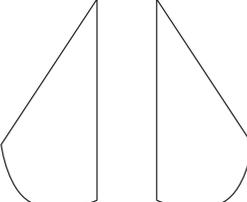
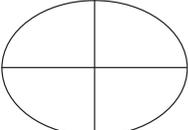
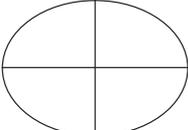
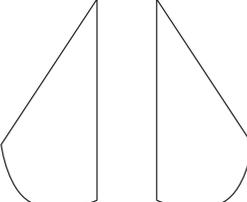
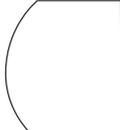
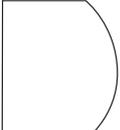
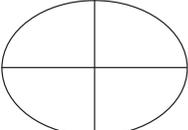
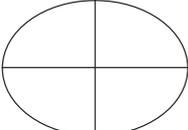
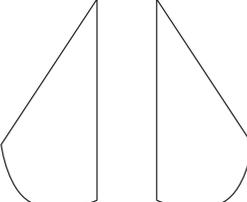
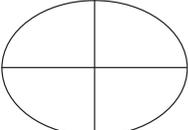
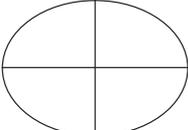
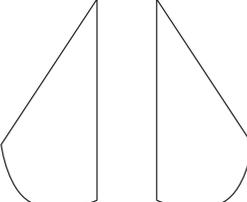
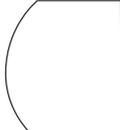
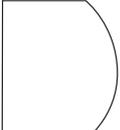
Moorabbin Hospital Monash Health Imaging
 823-865 Centre Road, East Bentleigh 3165.
 Ph: +61 3 9928 8828
 Email: mimaging@monashhealth.org

Casey Hospital Monash Health Imaging
 62-70 Kangan Drive Berwick 3806.
 Ph: +61 3 8768 1279
 Email: cimaging@monashhealth.org

Breast Imaging Referral Page 1 of 2

DI USE ONLY:
Appt Date & Time: _____

I dentify	Is an interpreter required? <input type="checkbox"/> Y <input type="checkbox"/> N	Any known allergies? <input type="checkbox"/> Y <input type="checkbox"/> N	Diabetic? <input type="checkbox"/> Y <input type="checkbox"/> N
	Language? _____	If yes, state allergies? _____	Hyperthyroidism? <input type="checkbox"/> Y <input type="checkbox"/> N
Patient pregnant? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A		Are extra infections precautions in place? <input type="checkbox"/> Y <input type="checkbox"/> N	Recent Creatinine/eGRF: _____
		Patient weight > 100kg? <input type="checkbox"/> Y <input type="checkbox"/> N	Date: ____ / ____ / ____

S ituation	Requester Details (Consultant details must be provided, otherwise referral will not be accepted)													
	<input checked="" type="radio"/> Requesting Consultant	<input checked="" type="radio"/> Fellow / Registrar	<input checked="" type="radio"/> RMO or authorised person											
	(Print) Name: _____	(Print) Name: _____	(Print) Name: _____											
	Baret Role: _____	Baret Role: _____	Baret Role: _____											
Mobile: _____ Mobile: _____ Mobile: _____ Provider number: _____ Provider number: _____ Provider number: _____														
Copy of Report to:														
<table style="width: 100%; border: none;"> <tr> <td style="width: 33%; text-align: center; border: none;">RIGHT BREAST</td> <td style="width: 33%; text-align: center; border: none;">LEFT BREAST</td> <td style="width: 33%;"></td> </tr> <tr> <td style="text-align: center; border: none;"></td> <td style="text-align: center; border: none;"></td> <td style="text-align: center; border: none;"></td> </tr> <tr> <td style="text-align: center; border: none;"></td> <td style="text-align: center; border: none;"></td> <td style="text-align: center; border: none;"></td> </tr> <tr> <td style="text-align: center; border: none;"></td> <td style="text-align: center; border: none;"></td> <td></td> </tr> </table>			RIGHT BREAST	LEFT BREAST										
RIGHT BREAST	LEFT BREAST													
														
														
														
Clinical Details:														

B ackground	Correlative Imaging (Please send relevant films and investigation results with patient)		
	Recent/Previous Imaging:	Date:	Place/Provider:
	<input type="checkbox"/> Mammography <input type="checkbox"/> Ultrasound <input type="checkbox"/> MRI

A ssessment	Provisional Diagnosis/Reason for Imaging:	

R equest	MRI: <input type="checkbox"/> Diagnostic <input type="checkbox"/> Screening <input type="checkbox"/> Biopsy Refer to Medicare rebatable MRI over the page. Please complete MRI safety checklist & examination being requested.	
	<input type="checkbox"/> Mammography <input type="checkbox"/> US <input type="checkbox"/> Localisation Magseed <input type="checkbox"/> Interventional Procedure (eg: biopsy, FNA) <input type="checkbox"/> CT <input type="checkbox"/> XRAY <input type="checkbox"/> Nuclear Medicine (PET - complete on dedicated PET request form)	
	(write in full) side and site of procedure	
	Preferred Date for imaging: ____ / ____ / ____	
<input type="checkbox"/> Sentinel lymph node procedure <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> BILATERAL <input type="checkbox"/> Periareolar <input type="checkbox"/> Peritumoral Date of surgery ____ / ____ / ____		

I verify that this is the correct patient, correct side and site of imaging request

Signature of Requester

Date

MRI Precautions (if Yes, please provide details)		
Cardiac Pacemaker / Defibrillator?	YES	NO
Neurostimulator?	YES	NO
Cerebral Aneurysm Clip?	YES	NO
Cochlear / Inner ear implant?	YES	NO
Vascular stents or coils?	YES	NO
Bullets / Shrapnel / Eye injury caused by metal?	YES	NO
Any other implant? Please specify:	YES	NO

Affix Patient Identification Label

Unit Record Number:

Surname:

Given Name:

D.O.B: Age: Sex:

Address:

.....

R

equest

Rebatable Breast MRI: For Medicare-funded studies, please select from the Medicare stipulated indications for MRI scans listed below:

- MBS Item 63464** - Patient is asymptomatic, AND patient is <60 years of age, AND patient is at high risk of breast cancer due to one of the following:
 - genetic testing has identified the presence of a high risk breast cancer gene mutation in the patient or in a first degree relative of the patient;
 - both:
 - one of the patient's first or second degree relatives was diagnosed with breast cancer at age 45 years or younger; and
 - another first or second degree relative on the same side of the patient's family was diagnosed with bone or soft tissue sarcoma at age 45 years or younger
 - the patient has a personal history of breast cancer before the age of 50 years;
 - the patient has a personal history of mantle radiation therapy;
 - the patient has a lifetime risk estimation greater than 30% or a 10 year absolute risk estimation greater than 5% using a clinically relevant risk evaluation algorithm
 - the service is not performed in conjunction with item 55076 or 55079
- MBS Item 63467** - Patient has had an abnormality detected as a result of a service described in item 63464 performed in the previous 12 months
- MBS Item 63487** - Patient has been diagnosed with metastatic cancer restricted to the regional lymph nodes; and clinical examination and conventional imaging have failed to identify the primary cancer
- MBS Item 63489** - BREAST MRI BIOPSY: Patient has a suspicious lesion on MRI but not on conventional imaging; AND an ultrasound scan of the affected breast, performed immediately before the biopsy, confirms that the lesion is not amenable to biopsy guided by conventional imaging
- MBS Item 63504 / 63505** - Determine implant integrity for patients who have or are suspected of having a silicone breast implant manufactured by Poly Implant Prosthesis (PIP)
- MBS Item 63531** - Patient has a confirmed breast lesion, AND Results of conventional imaging examinations are inconclusive, AND Biopsy has not been possible
- MBS Item 63533** - Patient has been diagnosed with breast cancer, AND A discrepancy exists between clinical assessment and conventional imaging assessment, AND The results of the breast MRI may alter treatment planning
- MBS Item 63545** – MRI Liver with a contrast agent for staging where surgical resection or interventional techniques are under consideration to treat any liver metastases detected. Computed tomography of the patient's liver must be negative or inconclusive for metastatic disease AND the identification of liver metastases would change the patient's treatment planning.
- MBS Item 63547** - Patient has breast implants and has been diagnosed with Anaplastic Large Cell Lymphoma

Non-rebatable Breast MRI: Out of pocket costs may apply:

- Full Diagnostic Breast MRI
- Abbreviated Breast MRI
- Assess Implant integrity

MRI Examination Requested

(Write in full) Side and Site of Procedure

Preferred Date for imaging ____ / ____ / ____