

IPM UR .....

TITANIUM ID .....

Name: .....

Address: .....

.....

Telephone: .....

Mobile: .....

Appointment Time: .....

DOB: ..... M / F

Interpreter required? **Yes**

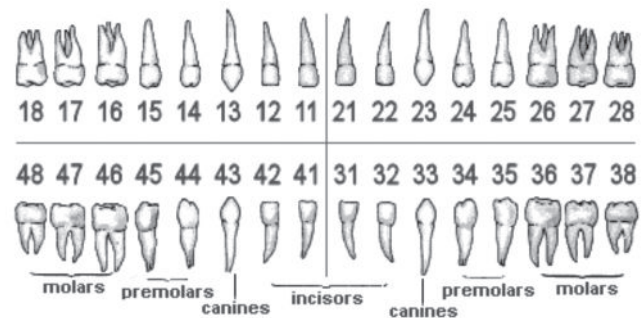
Language.....

Could patient be pregnant?  Yes  No

**Clinical Note:**

**Requested Dental Imaging**

- OPG 57960 Trauma, Infection, Congenital, Surgical
- OPG 57963 Impacted Teeth, Periodontal
- OPG 57966 Missing, Crowded, Abnormal Teeth
- OPG 57969 Temporomandibular Joints
- 57902 Lateral Ceph



**Referring Doctor Details:**

Name: .....

Address: .....

**Reports**

Images with patient Y / N

**Result**  Mobile/Landline number .....

Fax number .....

Healthlink EDI .....


**Copy of report to**

.....

Signature:..... Date:..... Provider No.: .....

**Billing Details**

MC Elect

 I assign my right to benefits to the approved radiology practitioner who will render the requested radiology service(s) and any eligible radiologist determinable service(s) established as necessary by the practitioner.

MC No: .....

Ref .No      Expiry Date

Patient's signature ..... Date .....

CLAYTON	DANDENONG	CASEY	MONASH CHILDREN'S HOSPITAL CLAYTON	MOORABBIN	KINGSTON	VICTORIAN HEART HOSPITAL	PAKENHAM HEALTH CENTRE
<b>Monash Health Imaging all sites: 9594 2200</b>							
Email: dicentral@monashhealth.org	Email: dhimaging@monashhealth.org	Email: cimaging@monashhealth.org	Email: mchimaging@monashhealth.org	Email: mimimaging@monashhealth.org	Email: mimimaging@monashhealth.org	Email: vhimaging@monashhealth.org	Email: cimaging@monashhealth.org

### Monash Imaging Use Only

<b>MIT / NMT / Sono 3C</b>	<p><b>Correct Patient</b> (Patient to state, Full name, DOB, Address ) where practical <i>Please tick 3 relevant Patient Identifiers before commencing examination</i></p> <p>Full name <input type="checkbox"/> DOB <input type="checkbox"/> Address <input type="checkbox"/> Wristband <input type="checkbox"/> Ankleband <input type="checkbox"/></p> <p>Ward / ED staff / Relative assisted with identity of patient <input type="checkbox"/></p>	<p><b>Pregnancy Check</b></p> <p>N/A <input type="checkbox"/></p> <p>Patient states "NOT" pregnant? Confirmed <input type="checkbox"/></p> <p>bHCG Value:(if applicable) .....</p>
	<p><b>Correct Procedure</b> Yes <input type="checkbox"/> No <input type="checkbox"/> (Patient verification with clinical history as required)</p>	
	<p><b>Correct Side/Site</b> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> <b>MIT / NMT /Sono (Signature):</b> .....</p>	
<b>Intervention Team</b>	<p><b>Time Out</b> (Interventional studies only, checklist completed by scout nurse) <b>NB: Performed immediately prior to commencement of intervention.</b></p> <p>1. Correct patient verified? Yes <input type="checkbox"/> Safe to proceed, step (2)</p> <p>2. Procedure matches consent? Yes <input type="checkbox"/> Safe to proceed, step (3)</p> <p>3. Correct side/site identified and marked with indelible pen? Yes <input type="checkbox"/> N/A <input type="checkbox"/> Safe to proceed, step (4)</p> <p>4. L/R orientation confirmed on in-room monitor/image acquisition system Yes <input type="checkbox"/> N/A <input type="checkbox"/> Safe to proceed MIT (initial) .....</p> <p>Date: ..... Time: .....</p> <p>Proceduralist / fellow / registrar: (PRINT name): ..... Nurse/MIT/Sono: .....</p> <p>Signed Proceduralist / fellow / registrar .....</p>	
	<b>Radiologist</b>	<p><b>Examination Details</b></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>
<b>Clerical</b>	<p>Films to be printed <input type="checkbox"/> Comments: .....</p> <p>CD to be burnt <input type="checkbox"/> .....</p> <p>Patient to take <input type="checkbox"/> .....</p>	
<b>MIT / NMT / Sono</b>	<p><b>RIS Procedure details</b></p> <p>Radiation Dose / Fluoroscopy time:</p> <p>Radiologist / NM Physician:</p> <p>MIT/NMT:</p>	<p>Contrast Medium &amp; Batch No:</p> <p>Type / Volume:</p> <p>Contrast Reaction? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Time when oral contrast given:</p>
	<p><b>Examination comments</b> (free text) <i>(no disparaging or inappropriate comments about the patient allowed here)</i></p>	<p><input type="checkbox"/> Patient uncooperative-movement</p> <p><input type="checkbox"/> No images obtained</p> <p><input type="checkbox"/> Some images obtained</p> <p><input type="checkbox"/> Pt Claustrophobic</p> <p><input type="checkbox"/> Pt rebooked for sedation</p> <p><input type="checkbox"/> Pt refused sedation</p>

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