Monash Health Imaging

Referral enquiries:
Monash Health Imaging
Ph: +61 3 9594 2200
E: dicentral@monashhealth.org

IPM UR .....

TITANIUM ID .....

Name: .....

Address: .....

.....

Telephone: .....

Mobile: .....

Appointment Time: .....

DOB: ..... M / F

Interpreter required? **Yes**

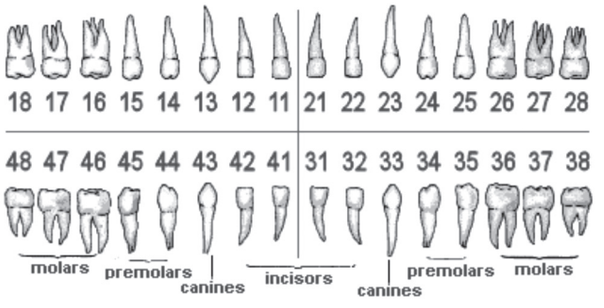
Language .....

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
Monash Health Imaging all sites: 9594 2200							
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: vhhimaging@monashhealth.org	Email: cimaging@monashhealth.org

173975 07/25

Monash Health
Imaging

Monash Imaging Use Only

MIT / NMT / Sono 3C

Correct Patient

(Patient to state, Full name, DOB, Address) where practical

Please tick 3 relevant Patient Identifiers before commencing examination

Full name ☐ DOB ☐ Address ☐ Wristband ☐ Ankleband ☐

Ward / ED staff / Relative assisted with identity of patient ☐

Pregnancy Check

N/A ☐

Patient states "NOT" pregnant? Confirmed ☐

bHCG Value:(if applicable) .....

Correct Procedure Yes ☐ No ☐ (Patient verification with clinical history as required)

Correct Side/Site Yes ☐ No ☐ N/A ☐ **MIT / NMT /Sono (Signature):** .....

Intervention Team

Time Out (Interventional studies only, checklist completed by scout nurse)

NB: 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:* .....

Proceduralist / fellow / registrar: (PRINT name): ..... Nurse/MIT/Sono: .....

Signed Proceduralist / fellow / registrar .....

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: .....

Clerical

Films to be printed ☐ Comments: .....

CD to be burnt ☐ .....

Patient to take ☐ .....

MIT / NMT / Sono

RIS Procedure details

Radiation Dose / Fluoroscopy time:

Radiologist / NM Physician:

MIT/NMT:

Contrast Medium & Batch No:

Type / Volume:

Contrast Reaction? Yes ☐ No ☐

Time when oral contrast given:

Examination comments (free text)

(no disparaging or inappropriate comments about the patient allowed here)

☐ Patient uncooperative-movement
☐ No images obtained
☐ Some images obtained
☐ Pt Claustrophobic
☐ Pt rebooked for sedation
☐ Pt refused sedation

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