

## Imaging Request

UR: \_\_\_\_\_  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

DOB: \_\_\_\_\_ M / F  
 Telephone (home): \_\_\_\_\_  
 Mobile: \_\_\_\_\_

- Examination requested**
- X-ray
  - Low Dose CT
  - Ultrasound
  - MRI
- Nuclear Medicine
  - Interventional
  - Fluoroscopy
  - 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

MRI Precautions (if Yes please provide details)			Any known allergies? _____	
Cardiac Pacemaker / Defibrillator?	YES	NO	Patient pregnant? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A	
Neurostimulator?	YES	NO	<b>Precautions</b>	Please specify
Cerebral Aneurysm Clip?	YES	NO	Are extra precautions in place?	
Cochlear / Inner ear implant?	YES	NO	Patient weight > 100kg?	
Vascular stents or coils?	YES	NO	Diabetic?	
Bullets / Shrapnel / Eye injury caused by metal?	YES	NO	Hyperthyroidism?	
Any other implant? Please specify:	YES	NO	Contrast studies Creatinine / eGFR:	Value: _____ Date: _____

**Monash Health Imaging Services -  
Phone 03 9594 2200**

	General X-Ray	Fluoroscopy	CT Scanning	Ultrasound (Inc Doppler)	MRI	Angiography	Nuclear Medicine	PET	OPG	Mammography	DEXA
<b>Monash Medical Centre - Clayton</b> 246 Clayton Rd Clayton Ph: 9594 2200 Email: dicentral@monashhealth.org	●	●	●	●	●	●	●		●		●
<b>Monash Children's Hospital - Clayton</b> 246 Clayton Rd Clayton Ph: 9594 2200 Email: mchimaging@monashhealth.org	●	●		●	●						
<b>Moorabbin Hospital</b> 823-865 Centre Road Bentleigh East Ph: 9928 8828 Email: mimaging@monashhealth.org	●	●	●	●	●		●	●		●	
<b>Dandenong Hospital</b> 135 David Street Dandenong Ph: 9554 8175 Email: dimaging@monashhealth.org MRI Ph: 9554 8685	●	●	●	●	●	●	●		●		
<b>Casey Hospital</b> 62-70 Kangan Drive Berwick Ph: 8768 1279 Email: cimaging@monashhealth.org	●	●	●	●		●	●		●	●	

(insert patient label)

## Monash Health Imaging Use Only

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

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