

## Monash Imaging MRI Prostate Request

UR: \_\_\_\_\_

DOB: \_\_\_\_\_

M / F

Name: \_\_\_\_\_

Telephone (home): \_\_\_\_\_

Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Mobile: \_\_\_\_\_

**Examination requested** (please tick which applies to your patient)

**Clinical Details**

**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

**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.: \_\_\_\_\_

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	Precautions	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 Imaging Use Only

Intervention Team	<p><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></p> <p>1. Correct patient verified? <input type="checkbox"/> Yes      Safe to proceed, step (2)</p> <p>2. Procedure matches consent? <input type="checkbox"/> Yes      Safe to proceed, step (3)</p> <p>3. Correct side/site identified and marked with indelible pen? <input type="checkbox"/> Yes    N/A <input type="checkbox"/> Safe to proceed, step (4)</p> <p>4. L/R orientation confirmed on in-room monitor/image acquisition system <input type="checkbox"/> Yes    N/A <input type="checkbox"/> Safe to proceed</p> <p>MIT (initial) .....</p> <p>Date: ..... Time: .....</p> <p>Interventionist / fellow / registrar: (PRINT name): ..... Signed: .....</p> <p>Nurse (PRINT name): ..... Signed: .....</p> <p>MIT / SONO / (PRINT name): ..... Signed: .....</p>	
Radiologist	<p><b>Examination Details</b>      Code: ..... Dr Initials: .....</p> <p>Protocol: .....      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>	
CT MIT/ NMT	<p><b>CT Preparation Checklist</b></p> <p>Patient Name: .....</p> <p>UR: .....</p> <p>Height: .....</p> <p>Weight: .....</p>	<p>3C's performed by ..... Yes <input type="checkbox"/>    No <input type="checkbox"/></p> <p>Previous CT's checked by ..... Yes <input type="checkbox"/>    No <input type="checkbox"/></p> <p>Recent eGFR ..... Yes <input type="checkbox"/>    No <input type="checkbox"/></p> <p>Remaining oral contrast given by ..... Yes <input type="checkbox"/>    No <input type="checkbox"/></p> <p>IV cannula checked by ..... Yes <input type="checkbox"/>    No <input type="checkbox"/></p> <p>..... (Please initial)</p> <p style="text-align: center;"><b>For Emergency or inpatients requiring IV contrast</b></p> <p>Does the patient have hyperthyroidism?      Yes <input type="checkbox"/>    No <input type="checkbox"/></p> <p>Suspected or diagnosed thyroid cancer?      Yes <input type="checkbox"/>    No <input type="checkbox"/></p> <p>Known allergies including iodine?            Yes <input type="checkbox"/>    No <input type="checkbox"/></p> <p>Is the patient taking metformin?              Yes <input type="checkbox"/>    No <input type="checkbox"/></p> <p>Does the patient have sickle cell anaemia?    Yes <input type="checkbox"/>    No <input type="checkbox"/></p> <p>Does the patient have myasthenia gravis?      Yes <input type="checkbox"/>    No <input type="checkbox"/></p> <p>Does the patient take Beta Blockers?         Yes <input type="checkbox"/>    No <input type="checkbox"/></p>

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