

Monash Imaging MRI Prostate Request

UR: DOB: M / F

Name: Telephone (home):

Address: Mobile:

.....

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Examination requested (please tick which applies to your patient)

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

Clinical Details

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
Monash Medical Centre - Clayton 246 Clayton Rd Clayton Ph: 9594 2200 Email: dicentral@monashhealth.org	●	●	●	●	●	●	●		●		●
Monash Children's Hospital - Clayton 246 Clayton Rd Clayton Ph: 9594 2200 Email: mchimaging@monashhealth.org	●	●		●	●						
Moorabbin Hospital 823-865 Centre Road Bentleigh East Ph: 9928 8828 Email: mimaging@monashhealth.org	●	●	●	●	●		●	●		●	
Dandenong Hospital 135 David Street Dandenong Ph: 9554 8175 Email: dimaging@monashhealth.org MRI Ph: 9554 8685	●	●	●	●	●	●	●		●		
Casey Hospital 62-70 Kangan Drive Berwick Ph: 8768 1279 Email: cimaging@monashhealth.org	●	●	●	●			●		●	●	

(insert patient label)

Monash Imaging Use Only

Intervention Team	Time Out (Interventional studies only, checklist completed by scout nurse, interventionist and imaging technologist) N.B. Performed immediately prior to commencement of intervention	
	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:	
Radiologist	Examination Details	
	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:	
CT MIT/ NMT	CT Preparation Checklist	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)
		For Emergency or inpatients requiring IV contrast
		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"/>	
	Place IV contrast label here	

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