

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

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

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

Phone: \_\_\_\_\_

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

Email: \_\_\_\_\_

Interpreter required? Y / N  
If yes, what language?

### Examination Requested

CT  MRI  Ultrasound  X-Ray

- Coronary Angiogram (CTCA)
- Calcium Score
- Cardiac Function
- TAVI Workup
- Aortogram (non-TAVI)
- Pulmonary Angiogram (CTPA)
- Pulmonary Venogram
- Other (please specify)

Preferred date for Imaging: \_\_\_\_\_

### CT Coronary 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 (obstructive) coronary artery disease and have been considered for coronary angiography
- Evaluation of coronary arteries prior to non-coronary cardiac surgery
- Exclusion of coronary anomaly
- Medicare criteria not met (patient paying fee)

### Clinical History (including clinical question to be answered)

### Referring Doctor Details

Copy of report to:

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

Contact Details: \_\_\_\_\_

Signature: \_\_\_\_\_

Provider No: \_\_\_\_\_

Date: \_\_\_\_\_

Precautions	Please specify	Any known allergies?	
Are extra infection precautions in place?		Patient pregnant? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A	
Patient weight >150kg?		<b>MRI Precautions (if Yes please provide details)</b>	
Diabetic?		Cardiac pacemaker / defibrillator?	Yes No
Hyperthyroidism?		Neurostimulator?	Yes No
Contrast studies Creatinine / eGFR:	Value:      Date:	Cerebral Aneurysm Clip?	Yes No
		Cochlear / Inner ear implant?	Yes No
		Vascular stents or coils?	Yes No
		Bullets / Shrapnel / Eye injury caused by metal?	Yes No
		Any other implant? Please specify:	Yes No

**Victorian Heart Hospital Cardiac Imaging**  
Ground Floor  
631 Blackburn Road Clayton 3168  
Ph: 03 9594 2200 - Option 6  
Email: vhhimaging@monashhealth.org

(insert patient label)

## Monash Health Imaging Use Only

Intervention Team	<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: .....	
Radiologist	<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:	
CT MIT/ NMT	<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>
		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.