

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?		MRI Precautions (if Yes please provide details)	
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	Time Out (Interventional studies only, checklist completed by scout nurse, interventionist and imaging technologist <i>N.B. Performed immediately prior to commencement of intervention</i>)	
	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	
	Patient Name:	3C's performed by Yes <input type="checkbox"/> No <input type="checkbox"/>
	UR:	Previous CT's checked by Yes <input type="checkbox"/> No <input type="checkbox"/>
	Height:	Recent eGFR Yes <input type="checkbox"/> No <input type="checkbox"/>
	Weight:	Remaining oral contrast given by Yes <input type="checkbox"/> No <input type="checkbox"/>
		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.