

**Monash Health Imaging
Interventional Radiology Referral Form**

Interventional Radiology Booking Office email address:
InterventionalRadiologyOPCMMC@monashhealth.org

UR Number (if known):

Patient Name:

Date of Birth:

Address:

Mobile:

Email Address:

Next of Kin	Name		Contact Number
Interpreter Required?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Preferred Language
New Patient?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Review Patient? YES <input type="checkbox"/> NO <input type="checkbox"/>
MEDICARE			
Medicare Number		Medicare Expiry	
GP DETAILS			
Name		Phone	
Address			
REFERRER DETAILS			
Referrer Name		Provider Number	
Hospital/Service Name		Contact Number	
Email Address		Referral Date	

REASON FOR REFERRAL
SYMPTOMS / PRESENTATION
MANAGEMENT TO DATE AND RESPONSE TO TREATMENT

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PREVIOUS IMAGING AND PATHOLOGY AS PER REFERRAL GUIDELINES (inc. location performed)

PAST MEDICAL HISTORY AND FAMILY HISTORY (if relevant)

CURRENT MEDICATIONS AND ALLERGIES

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PLEASE SELECT PROBLEM CATEGORY OR SELECT OTHER AND SPECIFY	
<p>Arterial</p> <p><input type="checkbox"/> Congenital or acquired Vascular Malformations (adult or paediatric)</p> <p><input type="checkbox"/> Arterial or visceral organ aneurysms</p> <p><input type="checkbox"/> Peripheral Arterial Vascular Disease</p>	<p>Venous</p> <p><input type="checkbox"/> Renal vascular access</p> <p><input type="checkbox"/> Lower limb varicose veins</p> <p><input type="checkbox"/> Venous insufficiency</p> <p><input type="checkbox"/> Acute or Chronic Deep Venous Thrombosis</p> <p><input type="checkbox"/> IVC Filter Management</p>
<p>Oncology</p> <p><input type="checkbox"/> Solid organ tumours (primary or metastatic) for consideration of thermal or chemical ablation</p> <p><input type="checkbox"/> Liver cancer (HCC) or Liver metastases for consideration of trans-arterial chemoembolization, thermal or chemical ablation or Selective Internal Radiation Treatment (SIRT)</p> <p><input type="checkbox"/> Metastatic disease for consideration of thermal ablation or embolisation</p> <p><input type="checkbox"/> Malignant venous obstruction</p>	<p>Gastrointestinal</p> <p><input type="checkbox"/> Recurrent GI bleeding (Haematemesis or Malena) in the setting of liver failure/cirrhosis</p> <p><input type="checkbox"/> Recurrent ascites in the setting of liver failure/cirrhosis</p> <p><input type="checkbox"/> Biliary obstruction or jaundice requiring percutaneous transhepatic biliary procedures (PTC),</p> <p><input type="checkbox"/> Biliary stone disease in patients not fit for surgical cholecystectomy.</p>
<p>Thoracic / Respiratory</p> <p><input type="checkbox"/> Chronic haemoptysis</p> <p><input type="checkbox"/> Lung tumours primary or metastatic for consideration of percutaneous thermal ablation</p> <p><input type="checkbox"/> Pulmonary arteriovenous malformations</p> <p><input type="checkbox"/> Chronic pulmonary hypertension for consideration of catheter directed therapy</p>	<p>Musculoskeletal and Chronic Pain</p> <p><input type="checkbox"/> Bone tumours (adult or children) for consideration of biopsy or thermal ablation</p> <p><input type="checkbox"/> Image guided neurolysis (e.g. coeliac, ganglion impar blockade or ablation)</p>
<p>Urological</p> <p><input type="checkbox"/> Symptomatic benign prostatic hypertrophy (BPH)</p> <p><input type="checkbox"/> Hydronephrosis for elective nephrostomy or ureteric stent insertion</p> <p><input type="checkbox"/> Renal cancer for consideration of image-guided percutaneous thermal ablation</p> <p><input type="checkbox"/> Angiomyolipoma</p> <p><input type="checkbox"/> Varicocele</p>	<p>Gynaecological</p> <p><input type="checkbox"/> Symptomatic uterine fibroids and/or adenomyosis</p> <p><input type="checkbox"/> Uterine arteriovenous malformation with chronic bleeding</p> <p><input type="checkbox"/> Fallopian tube recanalization procedures (HSG, FTR, lipiodol)</p> <p><input type="checkbox"/> Pelvic Congestion syndrome (pelvic venous reflux)</p>

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PROBLEM TYPE:

Other