OUTPATIENT/CLINIC REFERRAL

THS – South
Department of Radiology
Ph: 03 6166 8816 Fax: 03 6173 0425

MRI CONSULTATION

REQUESTING PRACTITIONER	PATIENT DETAILS/LABEL
SURNAME: INITIALS:	SURNAME: GIVEN NAME:
ADDRESS/CLINIC:	ADDRESS:
TELEPHONE:	DOB: Phone:
FAX:	
PROVIDER NO:	

REGION FOR INVESTIGATION: (Please circle one only per request)

BRAIN	CERVICAL SPINE	SHOULDER	HIP	MRCP	PELVIS FEMALE
+MRA +MRV	THORACIC SPINE	ELBOW	KNEE	LIVER	PELVIS RECTAL STAGING
BRAINLABS ONLY	LUMBAR SPINE	WRIST	ANKLE	RENALS	PELVIS FISTULA
PITUITARY	BRACHIAL PLEXUS	HAND	FOOT	ADRENALS	PELVIS OTHER
IAMs	FULL SPINE (cord compression/mets)			PANCREAS	MR ENTEROCLYSIS
ORBITS	CARDIAC	BREAST	OTHER _____		

MRI SAFETY SURVEY
MUST be completed by requesting doctor.

Has the patient ever had any of the following?
IfYES please complete red box on reverse.

Pacemaker	YES	NO
Heart Valve Replacement	YES	NO
Aneurysm Clips	YES	NO
Vascular coil, stent or filter	YES	NO
Cochlear implant	YES	NO
Eye Implant	YES	NO
Metal in eyes	YES	NO
Metallic foreign body	YES	NO
Infusion pump	YES	NO
Any other implants	YES	NO
Currently pregnant	YES	NO
Previous surgery in area requested	YES	NO
Claustrophobia	YES	NO
Is oral sedation required	YES	NO

A General Anaesthetic is required and I have obtained informed consent from the patient: YES NO

CLINICAL DETAILS — (must be included for all regions requested — forms will be returned if inadequate information)

Dr Signature:

Date:

Next Appt: Private Films: YES NO

Radiologist	RAD	Series

PRIORITY STICKER– Coordinator

PROTOCOL—Radiologist to complete

Standard

Other

eGFR: **Date:**

Contrast **YES** **NO**

Signature

MRI SAFETY CONSIDERATIONS

Do you have any of the following? Please circle YES or NO.

Pacemaker	YES NO	Heart Valve Replacement	YES NO
Aneurysms clips	YES NO	Previous surgery	YES NO
Metal in eyes	YES NO	Brain Shunt	YES NO
Inner ear implants	YES NO	Vascular coil, stent or filter	YES NO
Drug infusion pump	YES NO	Shrapnel or bullet	YES NO
Metallic foreign body	YES NO	Eye implants	YES NO
Artificial limb	YES NO	Hearing aid	YES NO
Claustrophobia	YES NO	Any other implants	YES NO

Female patients — Could you be pregnant? YES NO

Do you have any kidney disease? YES NO

DO YOU UNDERSTAND ALL THESE QUESTIONS? YES NO

Patient signature: **Date:**

Radiographer signature: **Date:**

SAFETY DETAILS — Referring doctor to complete

Implants: Type: Date implanted:
Hospital implanted at:

Metallic Foreign Body: **Type:** **Location**

Pregnancy: Week:

IMPLANT SAFETY — Radiographer to complete

All implants have been investigated and the patient is safe to scan at 3T MRI YES NO

This patient has an MRI conditional implant and the following conditions apply:

Radiographer: Date:

Office Use Only

Your doctor has recommended you use the Department of Medical Imaging at the Royal Hobart Hospital.
You may choose another provider but please discuss this with your doctor first.

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