# OUTPATIENT/CLINIC REFERRAL

**Royal Hobart Hospital**
**Department of Radiology**
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# MRI CONSULTATION

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

## REQUESTING PRACTITIONER

SURNAME: INITIALS:

ADDRESS/CLINIC:

TELEPHONE:
FAX:
PROVIDER NO:

## PATIENT DETAILS/LABEL

SURNAME: GIVEN NAME:

ADDRESS:

DOB: Phone:

UR NO:

Interpreter required YES NO Language _____

## 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?**

**If YES 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 |
| Previous surgery in area requested | YES NO |
| Currently pregnant | YES NO |
| Currently weight | _____ kg |
| **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

**Details must be included for ALL regions requested**
**Forms will be returned if inadequate information is provided**

**Consultant Name:** **Consultant Signature:**

**Date:**

Next Appt: Private Images: YES NO

Code:
Scanner:
Time:

**PROTOCOL—Radiologist to complete**

**STANDARD**

**OTHER**

**Contrast order**

**YES NO**

**Signature of radiologist:**

**Date:**

**Amount:** **Type:**

**Contrast administration by:**

**Date:**

**Creatinine:** **Date:**

**eGFR :**

**Office Use Only**

## MRI SAFETY CONSIDERATIONS

| | | | |
|---|---|---|---|
| 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 |
| | | Current Weight | _____kg |

**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

1.5T MRI YES NO

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

Radiographer: Date:

THS-S 133960 12/19 F&P 66072 DEC19 M10