Imaging Request

Patient

Examination Required

PLEASE BRING PREVIOUS FILMS FOR COMPARISON

IV Contrast Alert

Contrast Allergy
○ Yes ○ No

Renal Disease
○ Yes ○ No

Diabetes Metformin treatment
○ Yes ○ No

Creatinine level:

eGFR:

Date:

MRI
Indicate whether the following applies to your patient.

History of welding, grinding, sheet metal work
○ Yes ○ No

Cardiac pacemaker
○ Yes ○ No

Brain aneurysm clip
○ Yes ○ No

Cochlear implant
○ Yes ○ No

Intravascular coils, filters, stents
○ Yes ○ No

Obstetric Ultrasound Previous Uterine surgery/ Instrumentation
○ Yes ○ No

Number:

Date LMP:

Staff Use Only:
Time out section - tick to complete:
○ Correct Patient verified
○ Correct procedure, side & site
○ Correct Patient data
○ Patient consented and form signed

Clinical Notes

Referring Doctor (Please include provider no. and CC Dr.)

Signature

Date

Films & Report

○ With patient ○ Fax

Request for new referral pads

Your doctor has recommended that you use I-MED Radiology. You may choose another provider but please discuss this with your doctor first.

i-med.com.au