MEDICAL IMAGING REQUEST

Queensland Government

Royal Brisbane and Women's Hospital
Level 3, Ned Hanlon Building, Herston 4029
Phone: 3646 2606 Fax: 3646 5379

Metro North Hospital and Health Service

Print Form

Patient information sheets available at www.qheps.health.qld.gov.au/consent

UR..... ☐ Female ☐ Male ☐ Indeterminate

Family Name.....

Given Names.....

DOB...../...../.....

Home address.....

Phone Nos.....

☐ **Inpatient** Ward.....
☐ **Mobile** Bed No.....
☐ **Outpatient** Clinic.....
☐ **Private** Attn Dr.....
☐ **Bulk Bill**

☐ Routine
☐ Urgent
Date Req. by.....

Duty Radiologist - 73834
Women's Imaging – 68844
DEM After Hours - 67883

Imaging Requested

The aim of this imaging is to (tick one and explain)

☐ Confirm ☐ Exclude ☐ Define ☐ Progress of

RADIOLOGY FINAL CHECK

	YES
Patient identification verified	☐
Procedure & consent verified	☐
Correct side & site verified	☐
Correct patient data & side markers	☐

Radiographer/ Team Leader
Signature .....

Clinical Details (include relevant surgery, imaging and pathology results)

Pregnant? ☐ Yes ☐ No
Infectious? ☐ Yes ☐ No
Allergies? ☐ Yes ☐ No

Specify .....

Risk factors for **CT, MRI, IVP, Angiography**

☐ Nil **or**
☐ > 70 years ☐ Hx renal insufficiency
☐ Diabetic ☐ On Metformin

If yes to any of the above please complete

Creatinine ..... eGFR ..... Date .....

☐ Previous reaction to contrast

Details.....

Obligatory **MRI** questionnaire

Aneurysm clip	☐ Yes	☐ No	Programmable shunt	☐ Yes	☐ No
Embolisation coils	☐ Yes	☐ No	Metal prosthesis	☐ Yes	☐ No
Inner ear implant	☐ Yes	☐ No	Penetrating eye injury ever	☐ Yes	☐ No
Neuro/biostimulator	☐ Yes	☐ No	Stent	☐ Yes	☐ No
Heart surgery	☐ Yes	☐ No	Requires sedation/pain relief	☐ Yes	☐ No
Prosthetic cardiac valves	☐ Yes	☐ No	Requires GA	☐ Yes	☐ No
Cardiac pacemaker/wires	☐ Yes	☐ No	Claustrophobia	☐ Yes	☐ No
Vena cava filter	☐ Yes	☐ No	Able to lie flat	☐ Yes	☐ No

Radiologist protocol /Initial.....

☐ Today ☐ Next 2 days ☐ Next 5 days

Radiographers comments

Declaration: I have assessed the above risks to the patient for this examination

Requested by:..... Consultant Name .....

Signature: ..... Pager/Phone: ..... Date: .....

Time.....
Date.....
Room.....
Initials.....

Notice to the patient. For Medicare eligible examinations only: Your referrer has recommended that you use Queensland Health.
You may choose another provider but please discuss this with your referrer first.

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