MEDICAL IMAGING REQUEST

Queensland Government

The Prince Charles Hospital – Metro North Hospital and Health Service
Rode Rd Chermside Q 4032
0800-1700 (Mon – Fri) **Phone: (07) 3139 6209 Fax: (07) 3139 4253**
Emergency X-ray Dept **Phone: (07) 3139 5694 Fax: (07) 3139 6207**
Radiologist **Phone: (07) 3139 4263 A/Hours : (07) 3139 4000**

❒ Public
❒ Billable

Identify

Affix Patient Label Here

Patient Surname _____

Patient Given Names _____

UR Number _____

DOB: _____/_____/_____

❒ Female ❒ Male

Ward
Bed No.
Consultant

❒ **Walk** ❒ **O²**
❒ **Chair** ❒ **IV**
❒ **Bed** ❒ **Escort**
❒ **Mobile X-ray (ext 6874)**

MI Use Only

Appt Date: _____

Appt Time: _____

Situation

Clinical Details (eg mechanism of injury, region of interest, relevant surgery, imaging/pathology results)

Paediatric Patients – Weight _____kg

MRP Comments

Background

Please indicate		
Patient pregnancy declaration? Initials _____	Yes	No
Any extra infection precautions in place	Yes	No
Allergies (_____)	Yes	No
For Nuclear Medicine		
Weight _____kg		
MPS Consent form completed	Yes	No

Risk factors for CT, MRI, IVP, Angiography

❒ Nil OR ❒ > 70 years
❒ Hx of renal insufficiency
❒ Diabetic ❒ On Metformin

If Yes to any risk factors please complete
eGFR_____ Date _____

Previous contrast reaction ❒ Yes ❒ No

Assess

Provisional Diagnosis (Why is this imaging needed?) ❒ Confirm ❒ Exclude ❒ Define ❒ Progress of

Request

Examination Requested *(write in full) Side and Site of Procedure*

Does the patient need an Interpreter? Yes / No
Has the patient received an information sheet regarding their procedure?

Requester Details

(Print) **Name**: _____
Provider No: _____
Pager/ **Phone**: _____

I verify that this is the correct patient, side and site of imaging requested. I consider the benefits of this examination justify the risks to the patient.

Please tick

❒ ***Consultant***
❒ ***Registrar***
❒ ***RMO***
❒ ***Authorised person***
Specify:_____

MI Protocol

Contrast Oral ❒ IV ❒
Comments

Signature of Requester _____ **Date** _____

Forms will NOT be processed if incomplete or illegible – *see Queensland's Arrangements for Obtaining Diagnostic Procedures*

❒ **Urgent** *(Phone as below)*

❒ **Required by:** _____
(Date and Time)

Accession No: _____

CT (ED/Inpatient)	**Nurse T/L**
Ph: 3139 6431	Ph: 3139 5851
Fx: 3139 6207	Fx: 3139 4807

General X-ray	**Ultrasound**	**Nuclear Med**	**CT (OPD/CTCA)**	**MRI**
Ph: 3139 4258	Ph: 3139 4555	Ph: 3139 4251	Ph: 3139 4264	Ph: 3139 4599
Fx: 3139 4253	Fx: 3139 4253	Fx: 3139 4860	Fx: 3139 4807	Fx: 3139 4807

Medical Imaging FINAL CHECK

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

Team Leader Signature.....

V1/08

Queensland Government

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.

MEDICAL IMAGING REQUEST