Medical Imaging Request

Facility: .....

(Affix identification label here)

URN: 432100

Family name: Doe

Given name(s): John

Address:

Date of birth: 2/2/2002 Sex: ☐ M ☐ F ☐ I

Ward/clinic:	Date required by:	Transport:	Private
Bed 21		☐ Walk ☐ Chair ☐ Trolley ☐ Weight >150kg	☐ Yes

Request Details

Imaging requested: (please use separate forms per modality request) ☐ **Interpreter Required**

CXR

Imaging requested to: (tick one and explain)

☐ Confirm ☐ Exclude ☐ Define ☐ Assess progress of ☐ N/A (e.g. interventional)

Exclude consolidation

Clinical details:

Pregnant: ☐ No ☐ Yes If Yes - BHCG .....(Required for U/Sound)

Breast Feeding: ☐ No ☐ Yes

Allergies: ☐ Nil known ☐ Yes (detail: .....)

Infection risk (Contact/Airborne precautions required) ☐ No ☐ Yes (detail: .....)

18M with productive cough

Risk factors

Mandatory for contrast studies:

☐ Nil OR

☐ Greater than 70 years ☐ History of renal impairment

☐ Diabetic ☐ On Metformin

☐ Asthma ☐ Heart Disease

☐ Hyperthyroidism ☐ On ß - adrenergic blockers

If any risk factors indicated provide:

eGFR:	Test date:

Previous reaction to contrast: ☐ Yes ☐ No

Mandatory for MRI examinations:

MRI is contraindicated for some patients

Penetrating eye injury: ☐ Yes ☐ No

Implanted cardiac device: ☐ Yes ☐ No

Other implanted device: ☐ Yes ☐ No

If *yes*, specify:

Declaration:

I consider the benefits of this examination justify the risk to the patient.

Requested by:	Designation:	Signature:	Date:
Josh Case	Doctor		1/9/2020

Provider No.:	Contact number / pager:	Copy of report to:	Consultant:
1234567A	4321		

Departmental use only

Protocol / comments:

I elect to be bulk billed for this service.

☐ YES - Bulk Billable

☐ NO - Not Bulk Billable

Patient (Inititals) .....

Appointment date:	Time:	Accession No.:

Radiology Final Check

	YES
Patient identification verified	☐
Procedure verified	☐
Verbal consent obtained	☐
Correct side and site verified	☐
Correct patient data and side markers Initials:	

Team Leader Signature: .....

DO NOT WRITE IN THIS BINDING MARGIN

MEDICAL IMAGING REQUEST