Western Health MRI Referral

Western Hospital Telephone: 03 8345 6030
Facsimile: 03 8345 6933
Sunshine Hospital Telephone: 03 8345 0302
Facsimile: 03 8345 1620

UR _____

Patient's Name _____

DOB ____/ ____/ ____ Phone _____

Address _____

_____

_____

WD ❑ _____

OPD ❑

Dr F'up appt

__/ __/ __

DATE __/__/__ TIME ____
Booking Code _____
Time Allocation _____
WH □ SH □
Bloods Required Y □ N □
RADIOLOGIST _____
MRI PROTOCOL

OFFICE USE ONLY

If the information requested on this form is not complete the MRI Examination WILL NOT be performed.

Screening Questions

Does the patient require an **interpreter?**	Yes / No	If Yes, language
Has the patient had **surgery in the last 6 weeks?**	Yes / No	If Yes, what?
Is the patient **claustrophobic?**	Yes / No	If Yes, requires sedation? Yes / No
Are there any contra-indications to sedation? (eg cardio-pulmonary disease; protease inhibitors)	Yes / No	If Yes, what?

Does the patient have a/an

Cardiac pacemaker or **pacing** wires?	Yes / No	
Implantable **defibrillator**?	Yes / No	If Yes, MRI contra-indicated
Neurostimulator?	Yes / No	
Cochlear implant, Stapes implant or other ear implant?	Yes / No	
Intracranial **aneurysm clip**?	Yes / No	If Yes, MRI potentially contra-indicated*
Diabetes, hypertension, renal disease or is on Dialysis?	Yes / No	If Yes, provide eGFR _____ Date _____

Objects and conditions requiring further assessment: **(PLEASE CIRCLE AND ADVISE DETAILS)**

- Retained shrapnel / bullet / pellet: History of metal in the eye not removed by a doctor Yes / No _____
- Prosthetic Heart valves, cardiac or other vascular stent Yes / No _____
- IVC filter, vascular coils, surgical clips Yes / No _____
- Internal or external infusion pumps Yes / No _____
- Brain or spinal shunt tube (especially if programmable) Yes / No _____
- Penile implant, IUD Yes / No _____

EXAMINATION

CLINICAL NOTES

Referring Doctor .....

Address .....

Signed .....

Provider No. .....

Tel/Pager ..... Date ...../...../.....

Item 40234 Revised Dec 2011

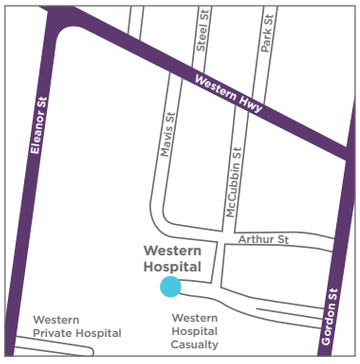
Western Health

Western Hospital and Sunshine Hospital is a provider hospital of Western Health

Western Health Medical Imaging

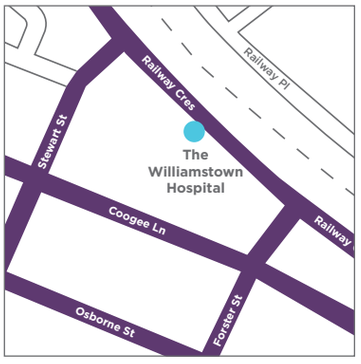
WESTERN HEALTH MEDICAL IMAGING SITES

Footscray



Sunshine

Williamstown



EXAMINATIONS	**Western Hospital** Gordon Street Footscray Phone: 03 8345 6234 Fax: 03 8345 6325	**Sunshine Hospital** 176 Furlong Road St Albans Phone: 03 8345 1664 Fax: 03 8345 1665	**Williamstown Hospital** Railway Crescent Williamstown Phone: 03 9393 0202 Fax: 03 9393 0306
Angiography	•		
CT	•	•	•
Fluoroscopy	•	•	•
Mammography	•	•	
MRI	•	•	
Nuclear Medicine	•	•	
OPG	•		
Ultrasound	•	•	•
X-ray	•	•	•

SPECIAL INSTRUCTIONS

CT CHEST, ABDO OR PELVIS
Nothing to eat or drink for 4 hours prior to appointment

MAMMOGRAPHY
Please bring previous mammography or breast Ultrasound films with you

NO Talc or deodorant to be used

ULTRASOUND ABDOMEN
Nothing to eat or drink for 8 hours prior to appointment

ULTRASOUND PELVIS
Arrive with a full bladder

NUCLEAR MEDICINE
Ring for appointment and provide a full list of medications

MRI
Please ring MRI for appointment instructions

FLUOROSCOPY
Please ring Medical Imaging for preparation instructions

Please complete details below and either
Telephone: 8345 6234
or
Facsimile: 8345 6933