Austin HEALTH

Austin Hospital

MRI REQUEST

FOR APPOINTMENTS PLEASE CALL: 9496 3463

APPOINTMENT

DATE: .....

TIME: .....

PATIENT DETAILS (OR AFFIX LABEL)

Name: .....

D.O.B.: ..... Phone: .....

Address: .....

.....

U.R. No. (if applicable) .....

Examination Required:

Renal Function - eGFR (mL/min) .....

Cr (umol/L) ..... Date: ... / ... / ...

Clinical Notes:

*Contraindications to MRI - Has the Patient **EVER** had:*

Cardiac pacemaker, cardiac/heart valve *No* ☐ *Yes* ☐

Neurostimulator or other electronically activated device *No* ☐ *Yes* ☐

Cerebral (brain) aneurysm clip *No* ☐ *Yes* ☐

Signature: ..... Pager: ..... Date: .....

REQUESTING CONSULTANT

NAME: ..... PROVIDER No.: .....

ADDRESS: ..... Postcode: .....

PHONE: ..... FACSIMILE: .....

REPORT: MAIL ☐ PHONE ☐ FAX ☐ ELECTRONIC TRANSMISSION ☐

IMAGES ☐ Required → FILMS ☐ or CD ☐

IMAGES ☐ Not Required

COPY TO: .....

BULK BILLING