



The Royal
Melbourne Hospital
Private Imaging

MRI Private Imaging Request

Radiology Appointments: 9342 7038
Nuclear Medicine Appointments: 9342 7480
Accounts: 9342 7028
Facsimile: 9342 7482
Website: www.mh.org.au/Radiology

Private Medical Centre
 The Royal Melbourne Hospital
 Royal Parade Parkville Vic 3050
 (location map & patient information over page)

Patient Details

Surname: Given Name:
 Date of Birth: Phone Number: Mobile:
 Address: Male Female

REPORT

Fax Email Deliver Phone
 Report & Films return with patient

IMAGE

Film
 CD

Preferred Date/Month of Examination

(Referrer to complete):

Next Available OR Month/Year

Copy Report to

CLINICAL INFORMATION

NO BOOKING will be made unless this section is completed and signed by the requesting doctor

- | | | | | |
|---|--|----------------------------------|--------------------------------|-----------------------------------|
| <input type="checkbox"/> Brain | <input type="checkbox"/> C-Spine | <input type="checkbox"/> MRCP | <input type="checkbox"/> Hip | <input type="checkbox"/> Shoulder |
| <input type="checkbox"/> Pituitary | <input type="checkbox"/> Thoracic Spine | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Knee | <input type="checkbox"/> Elbow |
| <input type="checkbox"/> Orbits | <input type="checkbox"/> Lumbar Spine | <input type="checkbox"/> Aorta | <input type="checkbox"/> Ankle | <input type="checkbox"/> Wrist |
| <input type="checkbox"/> Soft Tissue Neck | <input type="checkbox"/> Brachial Plexus | <input type="checkbox"/> Breast | <input type="checkbox"/> Foot | <input type="checkbox"/> Other |

Clinical Details (must be included)

MRI SAFETY SURVEY

Previous Surgery in Region Requested Yes No
 Is the patient pregnant? Yes No
 Is the patient breast feeding? Yes No

Has the patient EVER had any of the following? (please tick)

Pacemaker +/- Pacing Wires Yes No
 Heart Valve Replacement / Coronary Stents Yes No
 Aneurysm Clip Yes No
 Metallic fragments in eyes (e.g. from welding or grinding) Yes No
 Insulin Infusion Pump Yes No
 Cochlear Implants Yes No
 VP Shunt Yes No
 Breast Tissue Expander Yes No
 Vascular Coil Stent or Filter Yes No
 Neurostimulator Yes No
 Eye Implants Yes No
 Metallic Foreign Body Yes No
 Endoscopic Haemostatic Clips Yes No

If **YES** to any of the above please provide make and model and supporting documentation:

MRI CONTRAST CHECK

Patient >65 yrs old Yes No
 Renal Disease Yes No
 Diabetes Yes No
 High Blood Pressure Yes No
 Liver Disease Yes No

If **YES** to any of the above provide:

eGFR: Date of result:

Referring Doctor Details

Name: Provider No: Date:
 Address:
 Telephone: Fax: Signature:

Radiology use Only

Protocol / Book Details

Code No. of slots 1 2 3 4

RADIOLOGIST TO COMPLETE

Is the patient safe for MRI? Yes 1.5T only 1.5T or 3T
 No Why:

Radiologist:

MIT Initials/Comments

Private Imaging

Appointment Details

Date: Time:

Please bring the following to your appointment:

- Medicare, DVA or current concession card
- **Previous x-rays and scans** (films or CDs) for comparison
- Completed MRI safety questionnaire

Preparation Instructions for Patients

Detailed preparation instructions will be provided at the time of making an appointment.

On the day of your appointment please bring the completed MRI safety questionnaire.

Please advise us if you are diabetic when making an appointment.

Continue to take your medications as usual unless advised otherwise.

Instruction Notes

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The Royal Melbourne Hospital City Campus Site Map Melway Ref. 2B A7, B7

Private Imaging
Ground Floor of the Private Consulting Suites / Private Hospital
Phone 9342 7038

Public Radiology Department
Level 1, The Royal Melbourne Hospital
ED Radiology Department
Ground Floor, The Royal Melbourne Hospital
Phone 9342 2121

● Tram stop ● Bus stop ○ Taxi rank

- 1 Main entrance
- 2 Enquiries
- 3 Lifts to wards
- 4 Café
- 5 Pharmacy
- 6 Emergency Department
- 7 Private medical rooms/private hospital
- 8 Retail precinct
- 9 John Cade Building
- 10 Function Centre



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MRI REFERRAL PAD ORDER FORM

FAX TO: (03) 9342 8369

OR

CONTACT: MARY LAMBERT 0437 852 032

Please send me _____ new referral pad(s)

Drs Name: _____

Provider No. _____

Address: _____
