OUTPATIENT/CLINIC REFERRAL

Southern Tasmania Area Health Services (STAHS)
Department of Radiology
Ph: 6222 8816 Fax: 6231 3417

MRI CONSULTATION

REQUESTING PRACTITIONER	PATIENT DETAILS/LABEL
SURNAME: INITIALS:	SURNAME: GIVEN NAME:
ADDRESS/CLINIC:	ADDRESS:
TELEPHONE: FAX: PROVIDER NO:	DOB: Phone:

REGION FOR INVESTIGATION: (Please circle one only per request)

BRAIN	CERVICAL SPINE	SHOULDER	HIP	MRCP	PELVIS FEMALE
+MRA +MRV	THORACIC SPINE	ELBOW	KNEE	LIVER	PELVIS RECTAL STAGING
BRAINLABS ONLY	LUMBAR SPINE	WRIST	ANKLE	RENALS	PELVIS FISTULA
PITUITARY	BRACHIAL PLEXUS	HAND	FOOT	ADRENALS	PELVIS OTHER
IAMs	FULL SPINE (cord compression/mets)			PANCREAS	MR ENTEROCLYSIS
ORBITS	CARDIAC	BREAST	OTHER ______		

MRI SAFETY SURVEY
MUST be completed by requesting doctor.

Has the patient ever had any of the following? If YES please complete red box on reverse.

Pacemaker	YES NO
Heart Valve Replacement	YES NO
Aneurysm Clips	YES NO
Vascular coil, stent or filter	YES NO
Cochlear implant	YES NO
Eye Implant	YES NO
Metal in eyes	YES NO
Metallic foreign body	YES NO
Infusion pump	YES NO
Any other implants	YES NO
Currently pregnant	YES NO
Previous surgery in area requested	YES NO
Claustrophobia	YES NO
Is oral sedation required	YES NO

A General Anaesthetic is required and I have obtained informed consent from the patient:
YES NO

CLINICAL DETAILS — (must be included for all regions requested — forms will be returned if inadequate information)

Dr Signature:

Date:

Next Appt:		Private Films: YES NO
Radiologist	RAD	Series