MRI REQUEST

O'Connor
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South Street, O'Connor
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Bookings: 1300 209 975 | **E:** bookings@apexrad.com.au

Patient Details

Name: .....

Address: .....

.....

DOB: ..... / ..... / ..... Contact no: .....

Medicare: ..... Exp Date: ..... / .....

Please Tick:

- ☐ Vet Affairs
- ☐ HCC / Pension
- ☐ MVIT

Worker's Compensation

Claim no: Insurer:

PAYMENT IS REQUIRED AT TIME OF CONSULTATION

EXAMINATION REGION FOR INVESTIGATION:

☐ Brain	☐ Pituitary	☐ Cervical Spine	☐ MRCP	☐☐ Shoulder	☐☐ Hip
☐ Brain + MRA	☐ Orbits	☐ Thoracic Spine	☐ Upper Abdo	☐☐ Elbow	☐☐ Knee
☐ Temporal Lobe	☐ IAM's	☐ Lumbar Spine	☐ Pelvis	☐☐ Wrist	☐☐ Ankle
		☐ Brachial Plexus	☐ Breast	☐☐ Hand	☐☐ Foot

Other:

Implants: ☐ Saline ☐ Silicone

CLINICAL DETAILS (must be included):

DIFFERENTIAL Dx (s):

Please Tick:

- ☐ Creatinine .....
- ☐ EGFR .....
- ☐ Allergies .....

Requesting Practitioner

Copies of reports to: 1..... Sign:

"Your doctor has recommended that you use Apex Radiology. You may choose another provider but please discuss this with your doctor first."

MRI Safety Questionnaire and Body Map

Name: ..... DOB: ..... / ..... / .....

Weight: ..... Height: .....

GP's Name / Practice: .....

Certain Implants, devices and objects may be hazardous to you or may interfere with the MRI

Have you:

Had a previous MRI?	YES ☐	NO ☐
If yes, when and where?		
Ever had an eye injury caused by metal?	YES ☐	NO ☐
If yes, was this removed by a doctor?	YES ☐	NO ☐
Had any operations in the last six weeks?	YES ☐	NO ☐
Are you pregnant or suspect you might be pregnant?	YES ☐	NO ☐

Do you have, or have you ever had:

Cardiac pacemaker or Intra-Cardiac Defibrillator?	YES ☐	NO ☐
An artificial heart valve or wires?	YES ☐	NO ☐
Heart clips from cardiac surgery?	YES ☐	NO ☐
Aneurysm clips or coils?	YES ☐	NO ☐
Shunt in the brain or spinal cord?	YES ☐	NO ☐
Ear implant (Cochlear implant) or ear surgery?	YES ☐	NO ☐
Ocular Implant (Eye implant)?	YES ☐	NO ☐
Any implanted drug or other infusion pump?	YES ☐	NO ☐
A neurostimulator?	YES ☐	NO ☐
A bone growth stimulator?	YES ☐	NO ☐
An intra-uterine device (IUD)?	YES ☐	NO ☐
Any silver dressings?	YES ☐	NO ☐
Any pain patches or medication patches?	YES ☐	NO ☐
Removable plates / dentures?	YES ☐	NO ☐
Tattoo or permanent makeup?	YES ☐	NO ☐
Hearing aids?	YES ☐	NO ☐
Piercings / dermal piercings?	YES ☐	NO ☐
Hair extensions / wig / toupee?	YES ☐	NO ☐
Vascular stents, filters or coils? Where:	YES ☐	NO ☐
Any metal fragments or foreign bodies? Where:	YES ☐	NO ☐
Any other prosthesis, implants or devices? Please list:	YES ☐	NO ☐
Have you had any surgeries / operations in your lifetime? Please list:	YES ☐	NO ☐
Have you ever been diagnosed with cancer? Please specify:	YES ☐	NO ☐

I acknowledge that to the best of my understanding the above answers are true and consent to the MRI examination.

Patient signature: ..... Date: ..... / ..... / .....

Person completing the form if not the patient: ..... Relationship: .....

STAFF USE ONLY:

☐ Correct Patient ☐ Correct Procedure ☐ Patient is MRI safe Radiographer initials: .....