Imaging Office Use Only

NSW GOVERNMENT Health
Hunter New England Imaging

Examination Request Form

Dr B Soans & Associates Dr N Rutherford & Associates

PLEASE BRING PREVIOUS X-RAYS WITH YOU

Your doctor has recommended that you use Hunter New England Imaging.
You may choose another provider, but please discuss this with your doctor first.

PATIENT DETAILS (please print clearly)

Name FREDRICK CUNNINGHAM DOB 10.04.42 Sex (Tick Box) M ☒ F ☐

Date 17.05.2018

Address

MRN 000 0000

INPATIENT USE ONLY
(this section must be completed for all inpatients)

Ward: SURG Bed: 08

Treating Doctor: CROZIER

Pager/Phone: .....

PRIVATELY REFERRED OUTPATIENT
Please tick for privately referred outpatient ☐

CLINICAL QUESTION(S) TO BE ANSWERED (please print clearly)

STAGING CT FOR LIKELY INVASIVE ADENOCARCINOMA IN UPPER RECTUM.

EXAMINATIONS REQUESTED (please print clearly)

CT CHEST, ABDO + PELVIS + IV CONTRAST.

INFORMATION FOR MRI PATIENTS ONLY

If the patient has any of the following, please contact the MRI Unit at John Hunter Hospital on 492 13396 or Calvary Mater on 401 44603 prior to requesting the examination:

- Cardiac Pacemaker/Defibrillator
- Aneurysm Clip in the Brain
- Ear implant/Cochlear Implant/Bionic Ear
- Vascular Implant/Stent
- Implanted Drug Infusion Pump or Neuro Stimulator

NOTE: AN MRI SAFETY SCREENING FORM MUST BE COMPLETED FOR INPATIENTS AT THE TIME OF REQUEST

CONTRAST ALLERGIES

☐ Previous Reaction to Contrast

☐ Allergy(s) NO ONLY PENICILLIN

CONTRAINDICATIONS

☐ Asthma
☐ Diabetes
☐ Pregnant
☐ Breastfeeding
☐ LMP ___/___/___

☐ INR Level _____ (if on Warfarin)

☑ GFR Level 84 (if contrast required)

☐ No Contraindications

REQUESTING DOCTOR DETAILS

Name DR MARK CROZIER Date 17.05.18

Address

Provider Number

Tel Mob Fax

IS A COPY OF THE REPORT REQUIRED FOR?

☐ **LMO/GP**
Name
Address

☐ **SPECIALIST**
Name
Address

Requesting Doctor Signature x ..... **Date** x 17.05.2018

Medicare/Repat Number Valid to: Ref

Section 20A of the Health Insurance Act, 1973

I assign my right to benefits to the approved imaging service practitioner who will render the requested imaging services.

Patient Signature x..... Date x.....

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