theAlfred
Part of AlfredHealth

CARDIAC MRI FORM

If you wish to use this referral at an alternative provider, please discuss this with your doctor first

Phone: 9076 0357 Fax: 9076 0399 email: radiologybookings@alfred.org.au

Patient Details

Name:

Address:

Mobile / Best Contact Number:

Date of Birth:
Sex:

Medicare No.:
Pension card No:

Examination Requested

Clinical Details

✦Diabetic ? ☐ Yes ☐ No ✦On Metformin ? ☐ Yes ☐ No ✦Pregnant ? ☐ Yes ☐ No ✦Allergies ?

Referring Doctor Details

Name:
Address:

Telephone:
✦Fax:

Provider No.:

Signature: .....

Results (Tick all that apply)

☐ Intelerad (call 03 9076 0251 if you need an account)
☐ Fax
☐ Mail
☐ Images on CD
☐ Copy of report to (with fax number please):

.....

.....

Date:

MRI Screening Checklist (Alfred)

Please indicate whether the following applies to your patient:

MRI within the last 12 months	☐ Yes	☐ No
Cardiac pacemaker	☐ Yes	☐ No
Brain aneurysm clip	☐ Yes	☐ No
Cochlear Implant	☐ Yes	☐ No
History of welding, grinding, sheet metal work	☐ Yes	☐ No
Eye injury caused by metal	☐ Yes	☐ No
Claustrophobic	☐ Yes	☐ No
Any metal implant	☐ Yes	☐ No

Please describe (include make & model if known):

Billing Details

Does patient have symptoms or signs suggestive of ARVC?

☐ Yes (This will be a bulk billed scan)

☐ No (Charges may apply)

Administrative use only

MRN: Appt Date: Appt Time: