



CARDIAC MRI FORM

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

Patient Details

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

Name:

Date of Birth:

Sex:

Address:

Mobile / Best Contact Number:

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: