San RADIOLOGY AND NUCLEAR MEDICINE

Appointments: 02 9480 9840 | **Enquiries: 02 9480 9850**
San Radiology Level 3, Tulloch Building
Fax: 02 9480 9845
Nuclear Medicine/PET-CT Level 3, San Clinic
Fax: 02 9480 8755

MRI REQUEST – SPECIALISTS ONLY

Patient Name: ..... D.O.B .....

Address: ..... Postcode: .....

Phone: ..... Mobile:..... MRN: .....

Medicare-Eligible MRI Indications – Please provide detailed clinical notes in the section below

NB: The parentheses ( ) indicates the permitted number of MRI examinations in a 12 month interval)

BRAIN

- ☐ Stroke, TIA or vascular anomaly with intracranial MRA(3)
- ☐ Venous Thrombosis including MRV(3)
- ☐ Tumour or Inflammation of Brain, Meninges or Skull Base
- ☐ Demyelination(3)
- ☐ Epilepsy, Seizure or Trauma(3)
- ☐ Encephalopathy or Congenital Malformation(3)
- ☐ Pituitary Tumour(3)

NECK

- ☐ MRA – Extracranial (Carotid and Vertebral arteries)(3)

BRAIN AND CERVICAL SPINE

- ☐ Tumour
- ☐ Demyelination or inflammation(3)
- ☐ Syrinx or Congenital Malformation(3)

SPINE (Select region first then select the clinical indication)

☐ CERVICAL ☐ THORACIC ☐ LUMBAR

- ☐ Infection
- ☐ Tumour
- ☐ Demyelinating disease or Myelopathy(3)
- ☐ Congenital malformation of cord or to rule out Syrinx(3)

☐ **CERVICAL SPINE AND BRACHIAL PLEXUS**

- ☐ Tumour, Cervical Radiculopathy or Trauma(3)

- ☐ Radiculopathy/Sciatica(3)
- ☐ Trauma(3)
- ☐ Spinal canal stenosis(3)
- ☐ Previous spinal surgery(3) Describe: _____

☐ Previous surgery(3) Describe: _____

MUSCULOSKELETAL

- ☐ Shoulder(3) *(no arthrogram)* ☐ Left ☐ Right
- ☐ Shoulder(3) *(with arthrogram)* ☐ Left ☐ Right
- ☐ Elbow(3) ☐ Left ☐ Right
- ☐ Tumour, infection, osteonecrosis of bone or connective tissue
  Region: _____
- ☐ Hand, Wrist or Fingers(3) ☐ Left ☐ Right
- ☐ Hip(3) ☐ Left ☐ Right
- ☐ Knee(3) ☐ Left ☐ Right
- ☐ Ankle ☐ Left ☐ Right
- ☐ Foot/Toes(3) ☐ Left ☐ Right

BODY

- ☐ MRCP for suspected pancreas or biliary tree pathology(3)
  (*see Non-eligible procedures below for MRI Liver)*
- ☐ Abnormality of Thoracic Aorta SVC, IVC or Pelvic Vein(2)
- ☐ Adrenal mass in patient with an otherwise resectable malignancy(1)
- ☐ Congenital disease or tumour of Heart or other Great Vessel(2)
- ☐ Cardiovascular system for vascular abnormality in patient with previous anaphylactic reaction to iodinated contrast(3)
- ☐ Mediastinal mass (under 16 years)
- ☐ Congenital Uterine or Anorectal anomaly (under 16 years)
- ☐ Pelvis for initial staging of rectal cancer
- ☐ Abdomen and / or Pelvis for staging of proven Ca Cervix (FIGO Stage 1B or greater)
- ☐ MR Enterography for Crohn's
  - ○ Initial Diagnosis
  - ○ Exacerbation and/or Suspected Complications
  - ○ Pregnancy
  - ○ Therapy Change Assessment
- ☐ MR Enterography for Crohn's – Fistulising Perianal Evaluation
  - ○ Pelvic Sepsis and Fistulas
  - ○ Therapy Change Assessment

NON MEDICARE-ELIGIBLE MRI INCLUDING: *(NB: San Radiology has a dedicated Breast MRI request - contact us for further information)*

☐ Liver ☐ Prostate (PSA ____ on ___/___/___) ☐ Breast ○ Left ○ Right ○ Both ☐ Other Region *(please specify)* _____

CLINICAL NOTES

Please provide the following information for patients over 60 years of age or with known renal insufficiency who may require Gadolinium contrast as part of the examination.
Recent Creatinine: _____ Current eGFR: _____ Date: ___/___/___

SPECIALIST DETAILS

Name: .....
Signature: .....

Copy to: .....
Provider No: .....
Date: .....

Your doctor has recommended you use San Radiology and Nuclear Medicine. You may choose another provider but please discuss this with your doctor first.

PLEASE TICK FOR PRINTED IMAGES ☐
All images are available on-line only unless otherwise requested

0787/RAD/0618/DAS

FAX THIS REQUEST FORM TO SAN RADIOLOGY AHEAD OF MAKING YOUR APPOINTMENT

PLEASE REMEMBER TO BRING THIS REQUEST FORM AND ANY RELEVANT PREVIOUS IMAGING TO YOUR APPOINTMENT

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AND NUCLEAR MEDICINE

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185 Fox Valley Road
Wahroonga NSW 2076

MY APPOINTMENT DETAILS:

Appt Date: ...../...../.....

Appt Time: .....

Patient Checklist :

On the day of your appointment please bring:

- ☐ 1. Your MRI Referral (this document)
- ☐ 2. Previous relevant scans or x-rays for the region being examined.
- ☐ 3. Your Medicare, DVA or Healthcare Card (as applicable).
- ☐ 4. Any additional information requested by our staff at the time of appointment
- ☐ 5. Please wear as little jewellery and make-up as possible.

- MRI - High Resolution (3T)
- CT - Dual Source, ULTRA Low Dose
- General Ultrasound
- Vascular Ultrasound
- Echocardiography
- 2D/3D Mammography
- Digital X-Ray
- EOS® – Long Length Imaging
- Interventional Procedures
- PET-CT
- Nuclear Medicine
- Bone Mineral Densitometry

Patient Information:

Please allow approximately one (1) hour for your MRI appointment, even though your time on the MRI scanner may be considerably less.

MRI is a safe procedure and does not use radiation, however, patients with certain implanted metallic devices cannot be scanned safely. It is essential that you answer the safety questions below before making your appointment.

Please inform our reception staff if you have answered YES to ANY question, at the time of making your appointment, as further information may be required.

Patient Safety Questionnaire:

Please circle YES or NO for the following:

1. Do you have or have you had a:

Cardiac Pacemaker?	YES	NO
Implanted Cardiac Defibrillator?	YES	NO
Artificial Heart Valves or Annuloplasty Ring?	YES	NO
Neurostimulator?	YES	NO
Brain Aneurysm Clips?	YES	NO
Cochlear or Stapes Implant?	YES	NO
Other Metallic, Magnetic or Electric Implants?	YES	NO
Penile Implant?	YES	NO
Vascular Coil, Filter or Pump?	YES	NO

2. Are you Pregnant? YES NO
3. Do you have any metal objects in the eye? YES NO
4. Were you or are you a metal worker? YES NO

* If you are **DIABETIC**, please ensure you inform our staff at the time of your appointment as different preparation instructions may apply.

HOW TO FIND US:

- Enter the Hospital entrance at the traffic lights on Fox Valley Road (Entry 1)
- Park in P1 for San Radiology
- Park in P2 for Nuclear Medicine

NATA