# FHHS RADIOLOGY REQUEST FORM

ABN 55674 397 448

Accredited for compliance with
RANZCR Standards of Practice
for Diagnostic and Interventional Radiology

Patients are free to choose their own Imaging provider

General Enquiries .....Ph: 9431 2664 / Fax: 9431 2663

CT / US / Breast / BMD Appointments..Ph: 9431 2453 / Fax: 9431 2663

MRI / DSA / Screening Appointments.. Ph: 9431 3040 / Fax: 9431 3041

Portable X-rays / Plain X-ray enquiries Ph: 9431 2877 / A/H Ph:Switchboard

Results will be made available via PACS. Provisional dictations can be accessed via Mediweb

For URGENT After Hours CT contact the on call radiology registrar at Fiona Stanley Hospital via switchboard
For URGENT/EMERGENCY after hours plain x-rays contact the on call MIT via switchboard

## Patient

☐ Public
☐ Private

☐ Inpatient
Ward: .....

☐ Outpatient
Clinic: .....
Next Clinic Appt:
.....

USE STICKER WHEN AVAILABLE

UMRN:
Surname: .....
First Name: .....
Date of Birth: .....
Address: .....
.....
Phone No. : .....
Mobile No.: .....
Medicare No. : .....

### Patient Status

Pregnant ☐ Yes ☐ No
Weight: _____
Height: _____

### Communication

☐ Interpreter Required
Language:
.....

### Patient Transport

☐ Walking
☐ Chair
☐ Bed
☐ Stretcher
☐ Portable
☐ $O_2$
☐ IV
☐ Nurse Escort
☐ Monitored

## Request

### Clinical Details (include any relevant surgery and imaging/pathology results)

*Clinical Question to be Answered*

### Examination(s) Requested

## Practitioner

PLEASE PRINT CLEARLY OR USE STICKER / STAMP

Consultant in Charge: .....

Requesting Clinician: ..... Provider No: .....

Phone/Pager Number: .....

Signature: ..... Date:

APPROVED CONSULTANT SIGNATURE REQUIRED FOR ALL MRI REQUESTS. INCOMPLETE REQUEST FORMS WILL BE RETURNED AND MAY DELAY THE IMAGING OF YOUR PATIENT.

## Office Use

Radiologist / Protocol / Notes / Contrast & Dose:

| | |
|---|---|
| Patient Identification Verified | YES ☐ |
| Procedure and Consent Verified | YES ☐ |
| Correct SIDE and SITE Verified | YES ☐ |
| Correct patient data and side markers | YES ☐ |
| Patient pregnancy checked | YES ☐ |

MIT Signed: _____ Date: _____

## ESSENTIAL FOR PROCEDURES WITH CONTRAST

### Risk Factors

| | |
|---|---|
| Age >65 years | ☐Yes ☐No |
| Renal Impairment / Dialysis | ☐Yes ☐No |
| Diabetic | ☐Yes ☐No |
| Taking Metformin | ☐Yes ☐No |
| Nephrotoxic Medication | ☐Yes ☐No |
| Recent Iodinated Contrast | ☐Yes ☐No |
| Asthmatic | ☐Yes ☐No |
| Myeloma | ☐Yes ☐No |
| Heart failure / Shock | ☐Yes ☐No |

If **Yes** to any of the above ;

Creatinine: ..... Date: .....

Weight: ..... eGFR:.....

### Allergies

Has the patient had a previous reaction to contrast? ☐Yes ☐No

Details: .....
.....

Does the patient have any allergies? ☐Yes ☐No

Details: .....
.....

### IV Access

IV Cannula In-Situ ☐Yes ☐No

Site: .....

### Anticoagulation Therapy

Is the patient on anticoagulants or antiplatelet agents? ☐Yes ☐No

INR: .....

APPT: ..... Date: .....

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## Information for Administration of Contrast Medium

| | |
|---|---|
| UMRN: | OFFICE USE ONLY |
| Surname: …… | Serial No. Label |
| First Name: …… | |
| Date of Birth: …… | |
| Address: …… | |
| …… | |

The investigation you have been referred for may require an injection of x-ray contrast medium. This contrast medium improves the detection of abnormalities in the body and without its use, significant abnormalities may remain undetected.

During injection most patients report a transient feeling of warmth or a metallic taste in the mouth.

However, as with all drugs, side effects and adverse reactions are possible. Minor reactions usually consist of itching and facial swelling. More severe reactions can result in shortness of breath and low blood pressure. It is very rare for reactions to be life threatening, less than 1 in 100,000.

In this Radiology Department, we use the latest contrast media where side effects and adverse reactions are kept to a minimum and our staff are trained to deal with any side effects.

More serious adverse reactions are usually related to an allergy to contrast media.

**To reduce the risk of contrast reactions, please answer the following questions:**

| | |
|---|---|
| Have you had an **allergic** reaction to x-ray contrast media? | YES / NO |
| Are you allergic to Iodine? | YES / NO |
| Are you allergic to other drugs, bee stings, have eczema or asthma? | YES / NO |
| Do you have poor kidney function? | YES / NO |
| Are you breastfeeding? | YES / NO |
| Are you on **any** Diabetic medications? | YES / NO |

If you have any concerns, please raise them with a staff member prior to your study.

### Patient Acceptance

I have read and understood the above information. I give my permission to have an x-ray contrast injection as part of my examination.

Patient Name: _____ Date: _____

Patient Signature: _____
Or legal guardian

**Medical Officer** authorises contrast injection, the patient is unable to sign / has had a previous allergic reaction.

Medical Officer Name: _____ Signature: _____

If the following have been in attendance:

Interpreter's Name:_____ Signature: _____

Chaperone's Name:_____ Signature: _____