Please use I.D. label or block print

Government of **Western Australia**
**WA Country Health Service**

# Medical Imaging Request
## WACHS Midwest

*Patients are free to choose their own imaging provider*

- ☐ **Geraldton Hospital** ☎ 9956 2275 **Fax:** 9956 2321
- ☐ **Carnarvon Hospital** ☎ 9941 0420 **Fax:** 9941 0425
- ☐ **Exmouth Hospital** ☎ 9949 3696 **Fax:** 9949 3656

| LAST NAME | UMRN / MRN | |
|---|---|---|
| FIRST NAME | DOB | GENDER |
| ADDRESS | | POSTCODE |
| REFERRER'S PRACTICE | TELEPHONE | |

**BILLING:** ☐ WC ☐ MVIT ☐ DVA ☐ Private ☐ Medicare Other: _____

**MEDICARE No.** _____ **REF:** _____ **VALID TO:** _____

### Location
- ☐ **Outpatient**
- ☐ **Ward: bed/bay no.** _____
- ☐ **ED: bed/bay no.** _____

### Transport
- ☐ **Ambulant**
- ☐ **Wheelchair**
- ☐ **Bed / trolley**

### Infection Status
- ☐ **Standard**
- ☐ **Contact**
- ☐ **Droplet**
- ☐ **Airborne**

### Alerts
- ☐ **Microbiology Alert**
- ☐ **Diabetes / on Metformin**
- ☐ **Allergy to iodine / IV contrast**
- ☐ **Renal Impairment / transplant**

## Examination requested:
☐ **X-Ray** ☐ **Ultrasound** ☐ **Fluoroscopy** ☐ **CT**

**eGFR**: _____ **Date:** _____

**Creatinine:** _____ **Date:** _____

**Clinical Question to be answered:**

**Clinical details:**

**Referrer Name**: _____ **Provider Number:** _____

**I have considered the risks, including radiation, of this investigation and believe they are justified by the potential benefit to the patient.**

**Referrer Signature:** _____ **Date:** _____

**COPY OF RESULTS TO**: _____

***Medical Imaging Staff Use only***

MIT Exam Check:

- **Patient identification verified** ☐
- **Procedure and consent verified** ☐
- **Correct side and site verified** ☐
- **Correct patient data & markers** ☐

**MIT Initials:** _____

**Images / Films:** _____

**MIT Notes:**

**Item Numbers:** _____

## Patient to complete:

Are you or do you think you might be PREGNANT at the time of being x-rayed?

☐ **YES** ☐ **NO**

**LMP:** _____

I AGREE for the examination(s) shown on this form to be performed

**Patient Signature:** _____

**Date:** _____

Booking Details:

**Appt Date/Time:** _____

**Previous Reports:** _____

**Booked by:** _____

**Request Received:** _____

**Patient Arrived:** _____

**Exam Completed:** _____

Protocol / Preparation:

Office Use Only:

**Medical Imaging Request**

**Do not file in the Medical Record** / For Imaging Office Use only.

**Information for Administration of Intravenous Contrast Medium**

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 one (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 |
| Do you have **any allergies**? eg, medications, bee stings | YES / NO |
| Do you have **eczema** or **asthma**? | YES / NO |
| Do you have **poor kidney function, kidney disease or diabetes**? | YES / NO |
| Are you on **any diabetic medications**? eg metformin/diabex | YES / NO |
| Do you take **Interleukin-2** or have you taken it in the past 6 months? | YES / NO |
| Do you take **Beta Blockers**? (a medication for blood pressure and heart conditions) | YES / NO |
| Do you have an **overactive or underactive thyroid**? | YES / NO |
| Do you have a possible or confirmed **thyroid cancer**? | YES / NO |
| Do you take any **thyroid medications**? | YES / NO |
| Have you previously received or going to have **radioactive iodine treatment**? | YES / NO |
| Do you have **Myaesthenia Gravis / Sickle Cell Disease or Phaeochromocytoma**? | 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 of Birth:_____

Patient Signature: _____ Date: _____
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: _____

**Intravenous Contrast Details – Staff Use Only**

Dose/Type:

Expiry:

Batch Number: