GV Health MEDICAL IMAGING

Graham Street, Shepparton
All Enquiries Ph: (03) 5832 2320 Fax: (03) 5831 1103
Nuclear Medicine Ph: (03) 5823 0300 Fax: (03) 5823 0399

Appointment
Time_____
Date____/____/____

Patient Details

Full Name

Address

DOB
Sex
Medicare No.

Phone (M) (H)

Referring Doctor

Name

Address

Provider No.

Phone

Referring Doctor's Signature

..... Date .....

Copies to .....

Examination Required

Clinical Details

- ☐ X-Ray
- ☐ Ultrasound
- ☐ C.T. Scan (State eGFR if known below)
- ☐ OPG
- ☐ Fluoroscopy
- ☐ Biopsy/Drainage (Please complete pathology request)
- ☐ MRI (Complete MRI safety checklist below)
- ☐ Nuclear Medicine (Provided by Shepparton Nuclear Medicine - Keystone Radiology)

Please indicate current renal function.

eGFR _____ Date ____/____/____

Contrast given: (stick label here)

MRI SAFETY – ANSWERS ARE MANDATORY

Has the patient now or ever had:	Yes/No
An implanted pacemaker / pacing wire or defibrillator?	☐/☐
A cerebral aneurysm clip?	☐/☐
A cochlear or stapes implant?	☐/☐
Any metallic foreign bodies in the eyes?	☐/☐
Any metallic implants?	☐/☐
Is the patient pregnant or breastfeeding?	☐/☐
Surgery in the last 6 months?	☐/☐
Other implants?	☐/☐

PATIENT PREPARATION

GENERAL XRAY - none required

OBSTETRIC ULTRASOUND
Arrive with a comfortably full bladder (approx. 3 glasses 1 hour prior to examination).

RENAL & LOWER ABDOMEN, PELVIS ULTRASOUND
Drink 4 glasses of water (1 litre) within 20 minutes at least 1½ hours prior to appointment and hold until after examination.
Children: Please ring department for instructions

UPPER ABDOMEN ULTRASOUND
Nothing to eat or drink for 6 hours prior to the examination.

CT SCAN / NUCLEAR MEDICINE / MRI
Specific instructions will be given at time of making appointment.

BARIUM SWALLOW/MEAL/FOLLOW THROUGH
Nothing to eat or drink for 6 hours prior to the examination.

OFFICE USE ONLY

Protocol: _____

Radiologist Signature: _____

Date: _____/_____/_____

CSO:
- ☐ Personal information consent to obtain/forward
- ☐ Correct patient
- ☐ Correct procedure
- ☐ Correct side & site

Approval Initial: _____

MIT:
- ☐ Correct patient
- ☐ Correct procedure
- ☐ Correct side & site

Pregnant: ☐ Y ☐ N

Approval and Justification Initial: _____
- ☐ Contrast consent

Your doctor has recommended you undergo your diagnostic exam at GV Health. You may choose another provider but please discuss this with your doctor first.