Medical Imaging Request WACHS Kimberley

LAST NAME	UMRN / MRN
FIRST NAME	DOB GENDER
ADDRESS	POSTCODE
REFERRER'S PRACTICE	TELEPHONE
BILLING	
WC MVIT DVA Private Medicar	re Other

WACHS Kimberley															
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☐ BIOOITIE HOSPITAL P.9194	ZZ14 F.S	194 2207		Delby Hosp	ilai P.S	193 3220	T.9193	3221		J Kull	ununa no	Spilai F.9	100 4213	F.9100	4231
MEDICARE No:												Ref:		li	
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Clinical Details:										I AGF show	nages/reparted for the contract of the contrac	ports as he exam form to	part of my	y care) Y □ l med	N 🗆
Referrer Name:												ıging – I	Exam Ch	neck –	YES
Provider Number:										Patie	nt identifi	ication ve	erified	[3
I have considered the risks, including radiation, of this investigation and believe they are justified by the potential benefit to the patient.							Procedure and consent verified Correct side and site verified					_			
Referrer's Signature:				Date	:					Corre	ct patien	t data &	markers	С	3
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OFFICE US	E ONLY			PRO	IUCO	L/PREP	AKA TIO	N		Requ	est Recei	ved:			
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Effective: 11 December 2017

WPI 0002 03/16

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?					
Do you have any allergies? eg, medications, bee stings					
Do you have eczema or asthma ?					
Do you have poor kidney function, kidney disease or diabetes?					
Are you on any diabetic medications? eg metformin/diabex					
Do you take Interleukin-2 or have you taken it in the past 6 months?					
Do you take Beta Blockers ? (a medication for blood pressure and heart conditions)					
Do you have an overactive or underactive thyroid?					
Do you have a possible or confirmed thyroid cancer?					
Do you take any thyroid medications?					
Have you previously received or going to have radioactive iodine treatment?					
Do you have Myaesthenia Gravis / Sickle Cell Disease or Phaeochromocytoma?					
give my permission to have an x-ray	√ contrast injection				
Patient Name: Date of Birth:					
Date:					
tient is unable to sign / has had a pr					
_ Signature:					
Signature:					
Signature:					
	e or diabetes? n/diabex past 6 months? pressure and heart ? active iodine treatment? ase or Phaeochromocytoma? taff member prior to your study. give my permission to have an x-ray Date of Birth: Date: Signature: Signature:				

Intravenous Contrast Details – Staff Use Only

Dose/Type:

Batch Number:

Expiry: