



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

## Medical Imaging Request

### WACHS Pilbara

*Patients are free to choose their own imaging provider*

- Hedland Health Campus ☎ 9174 1477 Fax: 9174 1488
- Karratha Health Campus ☎ 9144 7777 Fax: 9144 7796
- Newman Hospital ☎ 9175 8332 Fax: 9175 8290
- Tom Price Hospital ☎ 9159 5205 Fax: 9159 5241
- Paraburdoo Hospital ☎ 9159 8221 Fax: 9159 8255

LAST NAME		UMRN / MRN	
FIRST NAME		DOB	GENDER
ADDRESS			POSTCODE
REFERRER'S PRACTICE		TELEPHONE	
BILLING: <input type="checkbox"/> WC <input type="checkbox"/> MVIT <input type="checkbox"/> DVA <input type="checkbox"/> Private <input type="checkbox"/> Medicare Other: _____			
MEDICARE No.		REF:	VALID TO:

Location	Transport	Infection Status	Alerts
<input type="checkbox"/> Outpatient	<input type="checkbox"/> Ambulant	<input type="checkbox"/> Standard	<input type="checkbox"/> Microbiology Alert
<input type="checkbox"/> Ward: bed/bay no. _____	<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Contact	<input type="checkbox"/> Diabetes / on Metformin
<input type="checkbox"/> ED: bed/bay no. _____	<input type="checkbox"/> Bed / trolley	<input type="checkbox"/> Droplet	<input type="checkbox"/> Allergy to iodine / IV contrast
		<input type="checkbox"/> Airborne	<input type="checkbox"/> 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: \_\_\_\_\_

**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 **Myaesthesia Gravis / Sickle Cell Disease or Pheochromocytoma**? 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: