Please use I.D. label or block print

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 5208 **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: ☐ 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: