

CARDIAC MRI REQUEST FORM

Phone 8177 1599 Fax 8177 1589
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Patient Details

Name _____

Address _____

Medicare No _____ Gender _____ DOB _____

Phone _____ Email _____

Clinical Details

Creatine _____ eGFR _____ Date _____

Contrast Allergy Yes | No _____ Pregnancy Yes | No _____ Renal Impairment Yes | No _____

Examination Requested

REBATABLE

- Myocardial Structure - ARVC
- Myocardial Structure - ARVC Asymptomatic Screening
- Myocarditis
- Congenital Disease
- Tumour Of The Heart
- Abnormality Of The Thoracic Aorta

NON-REBATABLE

- Non-rebatable Request (please provide details)

Cardiac Implantable Electronic Devices Yes | No (if yes, please provide details)

Model _____

Serial Number _____

Referring Doctor _____ Provider No _____

Signature _____ Date _____

Copy / Fax result to _____

Dr _____ Fax _____

Dr _____ Fax _____

This referral is not specific to Heart & Vascular

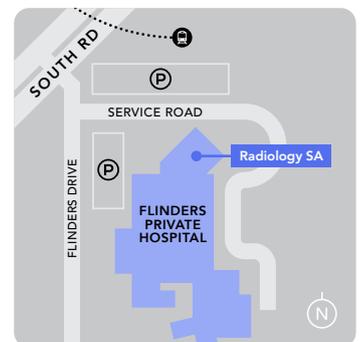
PATIENT PREPARATION

No caffeine/energy drinks for 24 hours prior to procedure

No Viagra, Cialis or similar for 36 hours prior to procedure

Fast 4 hours prior to procedure

Take other medications as per normal



All Cardiac MRI procedures performed at Radiology SA
Flinders Private Hospital
Suite 206, Ground Floor
1 Flinders Drive, Bedford Park