PAULINE GANDEL WOMEN'S IMAGING CENTRE

Medical Imaging Request *(not for obstetric use)*

Cnr Grattan St & Flemington Rd
Parkville VIC 3052 Australia
Tel 8345 2250 • Fax 8345 2259

the women's
the royal women's hospital

Patient details *(or affix label here)*

Name

Address

Hospital UR

Date of birth

Examination required

☐ General X-Ray ☐ Fluoroscopy ☐ CT
☐ Pelvimetry ☐ Bone density ☐ Ultrasound *(non obstetric)*
☐ Mammography +/- Ultrasound

Region

☐ MRI +/- Orbits +/-Skull +/- Chest X-Ray

History if welding, grinding, sheet metal work Yes / No

Cardiac pacemaker Yes / No

Brain aneurysm clip Yes / No

Cochlear implant Yes / No

Patient location

Consultant

Where *(tick one)*
☐ in dept
☐ in ward
☐ in theatre

Patient status *(tick one only)*
☐ public
☐ private
☐ bulk billed
☐ TAC

or specify

Send report by *(tick one)*
☐ phone
☐ fax
☐ post

D07-138

Clinical details *(please provide relevant information)*

Possibility of pregnancy **Unsure / Yes / No**

Requesting doctor details *(legally mandatory)*

Name Provider no

Pager or phone no Date

Sign here

Address or fax *(required to send report)*

CC