

PATIENT DETAILS

Name: _____

Address: _____

DOB: ____ / ____ / ____ Phone: _____

Workers Compensation **Claim Number** _____

MRI BULK BILLED examinations when referred by a General Practitioner

For patients **16 years or OLDER** (Please indicate the relevant clinical history)

MRI Brain - Item No. 63551

- Unexplained seizure(s) or
- Unexplained chronic headaches with suspected intracranial pathology.

MRI Cervical Spine - Item No. 63554

- Cervical radiculopathy. Symptoms: neck pain, numbness, weakness, tingling in fingers or hands, herniated disc, nerve damage, nerve impingement, bony spurs, headaches.

MRI Cervical Spine - Item No. 63557

- Cervical spine trauma.
- Any kind of neck injury.

MRI Knee - Item No. 63560

- Scan of the knee following acute knee trauma for a patient aged 16 - 49 years with: inability to extend the knee suggesting the possibility of acute meniscal tear; or clinical findings suggesting acute anterior cruciate ligament tear. (patients 50 years of age do not qualify)

For patients **UNDER 16 years** (Please indicate the relevant clinical history)

MRI Head, MRI Sinus - Item No 63507

- Unexplained seizure(s) or
- Unexplained headache where significant pathology is suspected; or
- Paranasal Sinus pathology which has not responded to conservative treatment.

MRI Spine - Item No 63510

- Following radiographic examination of any of the following assessment of significant trauma.
 - Unexplained neck or back pain with significant neurological signs.
 - Unexplained back pain with significant pathology suspected.

MRI Elbow - Item No 63519

- Following radiographic examination where a significant fracture or avulsion injury is suspected that will change management.

MRI Wrist - Item No 63522

- Following radiographic examination where scaphoid fracture is suspected.

MRI Hip - Item No 63516

- Following radiographic examination for any of the following:
 - Investigation of suspected septic arthritis.
 - Investigation of slipped capital femoral epiphysis.
 - Suspected Perthes Disease.

MRI Knee - Item No 63513

- Examination for internal joint derangement.

NOTE: MRI Liver now bulk billable if referred by a Specialist.

MRI Other Region (No Medicare Rebate)

CT Interventional Xray Ultrasound Nuclear Medicine DEXA Mammography

Examination Requested:

Clinical Information:

Filmless **More Request Pads** **Urgent**

Bulk Billing
For Medicare Eligible Items

REFERRER DETAILS

Name: _____ Specialty: _____

Address: _____

Phone: _____ Fax: _____ Provider No: _____

Signature: _____ Date: _____

MRI PATIENT SAFETY QUESTIONNAIRE

Please answer all of the following questions

If 'Yes' is answered to any questions, please inform staff when making your appointment.

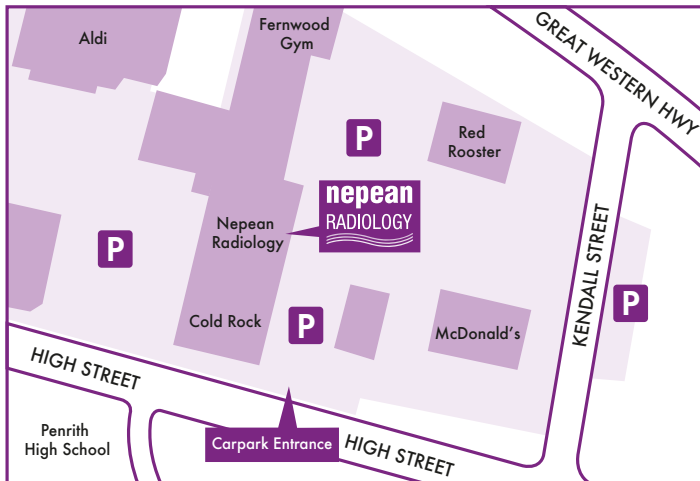
Aneurysm clip(s)	<input type="checkbox"/> YES <input type="checkbox"/> NO	Medication patch (Nicotine, Nitroglycerine)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Cardiac pacemaker	<input type="checkbox"/> YES <input type="checkbox"/> NO	Any metallic fragment or foreign body	<input type="checkbox"/> YES <input type="checkbox"/> NO
Implanted cardioverter defibrillator (ICD)	<input type="checkbox"/> YES <input type="checkbox"/> NO	Wire mesh implant (ie: hernia repair)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Electronic implant or device	<input type="checkbox"/> YES <input type="checkbox"/> NO	Tissue expander (e.g., breast)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Magnetically-activated implant or device	<input type="checkbox"/> YES <input type="checkbox"/> NO	Surgical staples, clips, or metallic sutures	<input type="checkbox"/> YES <input type="checkbox"/> NO
Neurostimulation system	<input type="checkbox"/> YES <input type="checkbox"/> NO	Joint replacement (hip, knee, etc.)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Spinal cord stimulator	<input type="checkbox"/> YES <input type="checkbox"/> NO	Bone/joint pin, screw, nail, wire, plate, etc.	<input type="checkbox"/> YES <input type="checkbox"/> NO
Internal electrodes or wires	<input type="checkbox"/> YES <input type="checkbox"/> NO	Dentures or partial plates	<input type="checkbox"/> YES <input type="checkbox"/> NO
Bone growth/bone fusion stimulator	<input type="checkbox"/> YES <input type="checkbox"/> NO	Tattoo or permanent makeup	<input type="checkbox"/> YES <input type="checkbox"/> NO
Cochlear, otologic, or other ear implant	<input type="checkbox"/> YES <input type="checkbox"/> NO	Body piercing jewellery that cannot be removed	<input type="checkbox"/> YES <input type="checkbox"/> NO
Insulin or other infusion pump	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hearing aid	<input type="checkbox"/> YES <input type="checkbox"/> NO
Implanted drug infusion device	<input type="checkbox"/> YES <input type="checkbox"/> NO	If YES, please remove before entering MR system room	
Any type of prosthesis (eye, penile, etc.)	<input type="checkbox"/> YES <input type="checkbox"/> NO	Undergone a pill cam procedure	<input type="checkbox"/> YES <input type="checkbox"/> NO
Heart valve prosthesis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Breathing problem or motion disorder	<input type="checkbox"/> YES <input type="checkbox"/> NO
Eyelid spring or wire	<input type="checkbox"/> YES <input type="checkbox"/> NO	Other implant	<input type="checkbox"/> YES <input type="checkbox"/> NO
Artificial or prosthetic limb	<input type="checkbox"/> YES <input type="checkbox"/> NO	If YES, please list	
Metallic stent, filter, or coil	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	
Shunt (spinal or intraventricular)	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	
Vascular access port and/or catheter	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	
Radiation seeds or implants	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	

Please list your previous surgery _____

What are your symptoms? _____

Your doctor has recommended that you use Nepean Radiology. You may choose another provider but please discuss this with your doctor first.

BANKSTOWN **BLAXLAND** **CHESTER HILL** **ERINA** **LEICHHARDT** **MT DRUITT** **PENRITH** **SPRINGWOOD** **ST MARYS**
 T: 02 8760 9100 T: 02 4702 3655 T: 02 8713 1855 T: 02 4363 9300 T: 02 9569 7223 T: 02 9854 0100 T: 02 4722 4700 T: 02 4702 3661 T: 02 9623 2550



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OFFICE HOURS

Monday to Friday 8.00am - 5.00pm

Saturday 8:30am - 12:30pm