



# BRIGHTON RADIOLOGY

www.brightonradiology.com.au  
(in development)

130 Male Street  
Brighton VIC 3186

## Imaging Request



# BAYSIDE STANDING MRI

www.baysidestandingmri.com.au

Phone: 0417 160 912

FAX: 9593 1876

### Patient Details

☐ Mr ☐ Mrs ☐ Dr ☐ Other: \_\_\_\_\_

First name: \_\_\_\_\_

Last name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

☐ Male ☐ Female ☐ Mixed

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Postcode: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_

### Imaging Request Details

Modality required: ☐ MRI ☐ X-Ray ☐ Ultrasound

Regions required:

*(For Lumbar Spine, SI joints, Lower Thoracic Spine & Knees, please specify if an Upright MRI scan is also required)*

Any other Clinical Details/Queries:

### Urgency

☐ Urgent ☐ Non-urgent

### Relevant previous imaging

☐ None ☐ Film ☐ Digital

### Referring Practitioner's Details

☐ Mr ☐ Mrs ☐ Dr ☐ Other: \_\_\_\_\_

Referrer name: \_\_\_\_\_

Specialty / Profession: \_\_\_\_\_

Provider Number: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Postcode: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Receive report method? ☐ Email ☐ Fax

Receive images method? ☐ CD ☐ Film (Additional charges apply for film)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Safety Check

Is there any chance the patient may be Pregnant? (Female Only)  
☐ Yes ☐ No (If 'yes' - x-rays cannot be performed)

Does the patient have a cardiac pacemaker/defibrillator?  
☐ Yes ☐ No (If 'yes' - MRI scans cannot be performed)

Does the patient have a cochlear implant or neurostimulator?  
☐ Yes ☐ No (If 'yes' - MRI scans cannot be performed)

Does the patient have a ventriculoperitoneal shunt?  
☐ Yes ☐ No (If 'yes' - MRI scans cannot be performed)

Does the patient have an intracranial aneurysmal clip?  
☐ Yes ☐ No (If 'yes' - MRI scans cannot be performed)

Has the patient had surgery in the last 6 weeks?  
☐ Yes ☐ No (If 'yes' - MRI scans cannot be performed)

Has the patient had a stapedectomy?  
☐ Yes ☐ No (If 'yes' - upper body MRI scans cannot be performed)

Does patient have an inserted pump/device?  
☐ Yes ☐ No (If 'yes' - unable to perform MRI scan in area of pump/implant/device)