Mater
Exceptional People. Exceptional Care.

Mater Misericordiae Ltd
Raymond Terrace
South Brisbane
Queensland, 4101

UR Number ☐ Male ☐ Female
Surname
Given name(s)
Address
Date of Birth Phone

Clinical areas MUST be completed by requesting Doctor

Imaging Request

Examination Requested:

Aim of the Investigation:
☐ Confirm ☐ Define
☐ Exclude ☐ Other

Clinical Details:

Is there a history of:

Previous contrast reaction	☐ Yes	☐ No
Allergies	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Pregnancy	☐ Yes	☐ No
Impaired Renal Function	☐ Yes	☐ No
eGFR	mml/min/1.73m²	

Patient Status:
☐ Inpatient ☐ MAH Ward / Area ☐ Walking ☐ Chair
☐ Outpatient ☐ MCH ☐ Stretcher Bed ☐ Portable
☐ Private ☐ MMH Contact No. ☐ Contact Precautions

Booking Information Medical Imaging Use Only:
Date: ☐☐ / ☐☐ / ☐☐☐☐
Time: ☐☐ : ☐☐

Requesting Consultant
Provider Number Speciality / Unit
Ordering Clinican
Provider Number Contact . Pager No.
Clinician's Signature Date

Contact Details:

Mater Medical Imaging				L.C.C.H	
Department phone no	3163 8754	Radiographer fax no	3163 1517	Radiologist Duty phone no	3068 4489
Department fax no	3163 1850	MRI phone no	3163 2182	Medical Imaging Bookings	3068 3009
Radiologist phone no	3163 8631	MRI fax no	3163 7536		

Medical Imaging Use Only

Patient Identification Verified ☐
Correct Side and Site Verified ☐
Procedure and Consent Verified ☐

Final Check

Correct Patient and Side Markers (Radiographer's Initials)

Procedure Team Leader's Signature:

Fore MRI - Does the patient have, or has the patient had, any of the following:

Vascular Clips / Heart Valves / Pacemaker	☐ Yes	☐ No
Cochlear / other Implanted Prosthesis / Stimulators	☐ Yes	☐ No
Implanted Pumps / Catheters / Stents / Devices	☐ Yes	☐ No
Claustrophobia	☐ Yes	☐ No
Intra Cranial Aneurysm Clip	☐ Yes	☐ No
Previous Brain Surgery	☐ Yes	☐ No
Does the patient require sedation / anaesthesia	☐ Yes	☐ No
Does the patient require lumbar puncture or blood	☐ Yes	☐ No

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