I-MED Radiology Network

Comprehensive care. Uncompromising quality.

Imaging Request

Patient

Examination Required

PLEASE BRING PREVIOUS FILMS FOR COMPARISON

IV Contrast Alert

Contrast Allergy
○ Yes ○ No

Renal Disease
○ Yes ○ No

Diabetes Metformin treatment
○ Yes ○ No

Creatinine level: .....

eGFR: .....

Date: .....

MRI

Indicate whether the following applies to your patient.

History of welding, grinding, sheet metal work
○ Yes ○ No

Cardiac pacemaker
○ Yes ○ No

Brain aneurysm clip
○ Yes ○ No

Cochlear implant
○ Yes ○ No

Intravascular coils, filters, stents
○ Yes ○ No

Obstetric Ultrasound Previous Uterine surgery/ Instrumentation
○ Yes ○ No

Number: .....

Date LMP: .....

Clinical Notes

Referring Doctor (Please include provider no. and CC Dr.)

Staff Use Only:
Time out section - tick to complete:

- ○ Correct Patient verified
- ○ Correct procedure, side & site
- ○ Correct Patient data
- ○ Patient consented and form signed

Signature

Date

Films & Report

○ With patient ○ Fax ○ Request for new referral pads

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