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Prostate MRI Referral Form

Patient Details

Name:

Address:

Date of Birth:

Medicare No.:

Pension Card No.:

Mobile/Best Contact Number:

Clinical Details

✶ Diabetic? ☐ Yes ☐ No ✶ Allergies?

Referring Doctor Details

Name:

Address:

Telephone:

Fax:

Provider No.:

Signature:

Results *(Tick all that apply)*

☐ Fax

☐ Mail

☐ Images on CD

☐ Copy of report to (with Fax No. please)

Date:

MRI Screening Checklist

Please indicate whether the following applies to your patient:

MRI within the last 12 months	☐ Y	☐ N
Cardiac pacemaker	☐ Y	☐ N
Brain aneurysm clip	☐ Y	☐ N
Cochlear Implant	☐ Y	☐ N
Eye injury caused by metal	☐ Y	☐ N
Claustrophobic	☐ Y	☐ N
Any metal implant	☐ Y	☐ N

Please describe (include make & model if known)

Indications for Prostate MRI

(Complete these questions for your patient)

Please include a recent PSA value

Has the patient had a recent DRE and was it suspicious? ☐ Y ☐ N

Clearly describe clinical symptoms

Has the patient family history of prostate cancer? ☐ Y ☐ N

Please give details:

Note: Relevant family history is a first degree relative with prostate cancer or suspected of carrying a BRCA 1, BRCA 2 mutation.

The patient is under active surveillance following a confirmed diagnosis of prostate cancer by biopsy? ☐ Y ☐ N