Private and Confidential

affidea

- nothing is more important than health

Radiology Referral Form

Referrals can only be accepted from a medical professional. Please complete this form clearly to help us process your referral promptly.

Patient Details

First name _____ Surname _____ Mobile _____

Gender identity Woman ☐ Man ☐ Non-binary ☐ Gender assigned at birth Female ☐ Male ☐ Intersex ☐

Address _____ Date of Birth (DD/MM/YYYY) ___/___/____

Med card Y ☐ N ☐ Private health insurance Y ☐ N ☐ Insurer name _____

Examination Required

MRI ☐ CT ☐ X-ray ☐ DXA ☐ Ultrasound ☐

Area to be examined _____

Detailed clinical information _____

Previous imaging Y ☐ N ☐ If Yes, please provide details _____

Does patient use: Wheelchair ☐ Crutches ☐ Other mobility aid _____

MRI

Does your patient have: Cardiac pacemaker: Y ☐ N ☐ Aneurysm clip: Y ☐ N ☐ Other implants: Y ☐ N ☐

If Yes, please provide details _____

MRI/CT

Previous contrast reactions: Y ☐ N ☐ History of Diabetes: Y ☐ N ☐

Any kidney or liver anomalies: Y ☐ N ☐ Allergies: Y ☐ N ☐

eGFR / Creatinine Level: _____ Current Medications: _____

For all radiology examinations, please indicate LMP data where relevant _____

Referring Details

Referrer title: Dr Ms/Mr Prof (please circle one) Referrer's Name _____ Practice Name _____

IMC/CORU _____ Other Professional No _____ Contact No _____ Fax _____

Address _____ Signature _____

Patient Safety

- Please note that certain radiology examinations in pregnancy may put the unborn infant at risk.
- For MRI, cardiac pacemakers, aneurysm clips, shunts, cochlear implants, intra-ocular implants, metallic foreign bodies, some surgical implants and early pregnancy are contraindicated.
- Please indicate previous history of contrast reactions, allergies, medications, renal failures, liver disease, diabetes, etc.

Fax this form to Affidea at:

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