CARDIAC MRI REFERRAL

SUBJECT DETAILS:

Name: ..... **Male:** ☐ **Female:** ☐ **Date of Birth:** .....

Address: .....

.....

T: ..... **M:** ..... **E:** .....

REQUESTING PRACTITIONER

Name

Address

Email

Fax

Research Project: At Baker IDI it is our aim to integrate clinical and research aims to improve patient care.
Patients will be asked if they are willing to have their anonymised data used for research regarding quality control and assessments of the incremental value of advanced imaging for refining diagnosis and changing clinical management.

How would you like the report to be provided?

☐ **Email** ☐ **Fax** ☐ **Post**

CLINICAL NOTES

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MRI safety *(To be completed by referrer)*

Has the patient ever had an:

	Yes	No		Yes	No
Eye Injury caused by metal	☐	☐	**Cardiac Pacemaker**	☐	☐
Cochlear Implant	☐	☐	**Aneurysm Clip**	☐	☐
Neurostimulator	☐	☐	**Other Metallic Implant**	☐	☐
			Please Explain;		

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MRI referral submission - Please email to alfredcentrereception@bakeridi.edu.au, or fax to 85321899. For any questions regarding bookings phone Baker IDI Clinics on 85321800
For questions regarding clinical indications please contact A/Prof. André La Gerche on andre.lagerche@bakeridi.edu.au. All patients will be required to complete an MRI safety questionnaire prior to their scan which will be provided when booking.

Date Prepared: September 2016