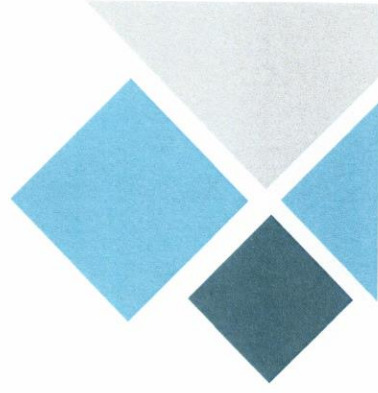


RURAL MEDICAL IMAGING



X-Ray | Ultrasound | CT | OPG | BMD | ECHO | Calcium Scoring

Patient Details:

Name:

DoB:

Address:

Phone:

Medicare or DVA No:

Examination Details:

Clinical Details:

Pregnant: Yes ___/___ No

Referring Doctor:

Name:

Address:

Provider No:

Phone:

Fax:

Signed:

Date:

Your Doctor has recommended that you use Rural Medical Imaging. You may choose another provider, but please discuss this with your doctor first.

CT Scan - IV Contrast Risk
Please indicate any of the following

>70yrs Hypertensive
 Diabetic Renal Insufficiency
 On any Metformin based medication
 Congestive Heart Failure
 Previous Contrast Reaction (Specify).....
.....
 Allergies (Specify).....
.....

If YES to any, eGFR levels (within one month of appointment date) are required.
eGFR: Date: / /

CT ANGIO / CT PAs

This patient's case has been discussed with a specialist or Consultant Physician

Signed _____

Patient Safety Check

1. Patient ID:
2. Consent Obtained:
3. Procedure Confirmed:
4. Site Confirmed:

Admin Sign: _____

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Innisfail Food Emporium
16A1 - 5 Owen St
Innisfail
Ph: 4061 7006
Fax: 4061 7008

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30 Mabel Street
Atherton
Ph: 4091 3377
Fax: 4091 7974

RMI Mareeba
The Post Office Centre
94 Byrnes Street
Mareeba
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RMI Ingham
22 Heard Street
Ingham
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