

# CARDIAC CT & NUCLEAR MEDICINE SCAN



## QUANTUM RADIOLOGY

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### PATIENT DETAILS

Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

#### EXAM REQUIRED - CARDIAC CT SCAN

- CARDIAC CT ANGIOGRAPHY
- CARDIAC CT PULMONARY ANGIOGRAPHY
- OTHER \_\_\_\_\_

#### EXAM REQUIRED - NUCLEAR MEDICINE SCAN

- MYOCARDIAL PERFUSION  
(Exercise/Pharmacologic)
- V/Q SCAN
- GATED CARDIAC BLOOD POOL SCAN

#### CLINICAL INDICATION/S

- Medicare eligible scan NOTE: Specialist referral only *(Indicates prerequisite symptom/s plus other significant symptoms)*
  - Stable symptoms consistent with coronary ischaemia, at low to intermediate risk of coronary artery disease and would have been considered for angiography
  - Exclusion of coronary artery anomaly or fistula
- Non-Medicare eligible scan
  - Undergoing non-coronary cardiac surgery
  - Workers Compensation

#### MEDICAL HISTORY/OTHER RELEVANT SYMPTOMS *(includes previous revascularisation procedures)*

- |  |   |       |
|--|---|-------|
| <input type="radio"/> Prior Myocardial Infarct | <input type="radio"/> Prior Coronary Stent  | _____ |
| <input type="radio"/> Heart Failure            | <input type="radio"/> Renal Impairment      | _____ |
| <input type="radio"/> Diabetes                 | <input type="radio"/> Coronary Bypass Graft | _____ |
| <input type="radio"/> ECG Findings             | <input type="radio"/> Pacemaker             | _____ |

Please inform us at the time of booking if any of the below boxes are ticked, as the scan may not be possible.

- Atrial Fibrillation / High Grade Ectopy
- Advanced Heart Block
- Pacemaker

#### CURRENT MEDICATION

- |   |                                 |
|---|---------------------------------|
| <input type="radio"/> Beta Blocker        | <input type="radio"/> Other CCB |
| <input type="radio"/> Verapamil/Diltiazem | <input type="radio"/> Digoxin   |
| <input type="radio"/> ACEI/ARB            |                                 |
| <input type="radio"/> Other _____         |                                 |

#### RISK FACTORS

- Smoker  Current  Ex-Smoker >1 year  Hypertension  Hyperlipidaemic  Diabetes  Family History

#### ALLERGIES

- No  Yes

eGFR: \_\_\_\_\_ Date: \_\_\_\_\_

- Iodine  Other \_\_\_\_\_

ARE THERE ANY CONTRAINDICATIONS TO GIVING THE PATIENT BETA BLOCKERS. YES  NO  \_\_\_\_\_

ARE THERE ANY CONTRAINDICATIONS TO GIVING THE PATIENT CORALAN. YES  NO  \_\_\_\_\_

REPORT  Urgent  More Request Pads  Films

**Bulk Billing**  
For Medicare Eligible Items

#### Referrer Details

Name: _____	Specialty: _____
Address: _____	
Phone: _____	Fax: _____
Signature: _____	Provider No: _____
	Date: _____

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