GP MRI CRITERIA

REFERRAL REQUEST

Dr Tinku Kooner • Dr Mansoor Parker • Dr Pon Ketheswaran
Dr David Chadban • Dr Bit Wong • Dr Prasad Kundum • Dr Sandeep Tiwari
Dr Georges Hazan • Dr Tom Sing • Dr Farhana Younis • Dr Kuan-Ching Ho
Dr Heba Abdelrahman • Dr Katherine Wong • Dr Ahmed Bassiouny
Dr Dhivya Balasubramaniam • Dr Jonathan Tow • Dr Ragu Yogaratnam

QUANTUM RADIOLOGY

PATIENT DETAILS

Name: _____

Address: _____

_____

D.O.B: ____ / ____ / ____ Phone: _____

○ **Workers Compensation** **Claim Number** _____

MRI BULK BILLED examinations when referred by a General Practitioner

For patients 16 years or **OLDER** *(Please indicate the relevant clinical history)*

MRI Brain - Item No. 63551
- ○ Unexplained seizure(s) or
- ○ Unexplained chronic headaches with suspected intracranial pathology.

MRI Cervical Spine - Item No. 63554
- ○ Cervical radiculopathy. Symptoms: neck pain, numbness, weakness, tingling in fingers or hands, herniated disc, nerve damage, nerve impingement, bony spurs, headaches.

MRI Cervical Spine - Item No. 63557
- ○ Cervical spine trauma.
- ○ Any kind of neck injury.

MRI Knee - Item No. 63560
- ○ Scan of the knee following acute knee trauma for a patient aged 16 - 49 years with: inability to extend the knee suggesting the possibility of acute meniscal tear; or clinical findings suggesting acute anterior cruciate ligament tear.

(patients 50 years of age do not qualify)

For patients **UNDER** 16 years *(Please indicate the relevant clinical history)*

MRI Head, MRI Sinus - Item No 63507
- ○ Unexplained seizure(s) or
- ○ Unexplained headache where significant pathology is suspected; or
- ○ Paranasal Sinus pathology which has not responded to conservative treatment.

MRI Spine - Item No 63510
- ○ Following radiographic examination of any of the following assessment of significant trauma.
  - Unexplained neck or back pain with significant neurological signs.
  - Unexplained back pain with significant pathology suspected.

MRI Elbow - Item No 63519
- ○ Following radiographic examination where a significant fracture or avulsion injury is suspected that will change management.

MRI Wrist - Item No 63522
- ○ Following radiographic examination where scaphoid fracture is suspected.

MRI Hip - Item No 63516
- ○ Following radiographic examination for any of the following:
  - Investigation of suspected septic arthritis.
  - Investigation of slipped capital femoral epiphysis.
  - Suspected Perthes Disease.

MRI Knee - Item No 63513
- ○ Examination for internal joint derangement.

NOTE: *MRI Liver now bulk billable if referred by a Specialist.*

MRI Other Region (No Medicare Rebate) _____

☐ **CT** ☐ **Interventional** ☐ **Xray** ☐ **Ultrasound** ☐ **Nuclear Medicine** ☐ **DEXA** ☐ **Mammography**

Examination Requested:	Clinical Information:

○ **Films** ○ **More Request Pads** ○ **Urgent**

Bulk Billing
For Medicare Eligible Items

REFERRER DETAILS

Name: Specialty:

Address:

Phone: Fax: Provider No:

Signature: Date:

EXPERIENCE INNOVATION

MRI PATIENT SAFETY QUESTIONNAIRE

Please answer all of the following questions

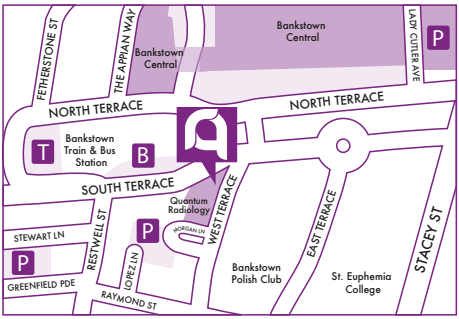
If 'Yes' is answered to any questions, please inform staff when making your appointment.

Aneurysm clip(s)	☐ YES ☐ NO	Medication patch (Nicotine, Nitroglycerine)	☐ YES ☐ NO
Cardiac pacemaker	☐ YES ☐ NO	Any metallic fragment or foreign body	☐ YES ☐ NO
Implanted cardioverter defibrillator (ICD)	☐ YES ☐ NO	Wire mesh implant (ie: hernia repair)	☐ YES ☐ NO
Electronic implant or device	☐ YES ☐ NO	Tissue expander (e.g., breast)	☐ YES ☐ NO
Magnetically-activated implant or device	☐ YES ☐ NO	Surgical staples, clips, or metallic sutures	☐ YES ☐ NO
Neurostimulation system	☐ YES ☐ NO	Joint replacement (hip, knee, etc.)	☐ YES ☐ NO
Spinal cord stimulator	☐ YES ☐ NO	Bone/joint pin, screw, nail, wire, plate, etc.	☐ YES ☐ NO
Internal electrodes or wires	☐ YES ☐ NO	Dentures or partial plates	☐ YES ☐ NO
Bone growth/bone fusion stimulator	☐ YES ☐ NO	Tattoo or permanent makeup	☐ YES ☐ NO
Cochlear, otologic, or other ear implant	☐ YES ☐ NO	Body piercing jewellery that cannot be removed	☐ YES ☐ NO
Insulin or other infusion pump	☐ YES ☐ NO	Hearing aid	☐ YES ☐ NO
Implanted drug infusion device	☐ YES ☐ NO	If YES, please remove before entering MR system room	
Any type of prosthesis (eye, penile, etc.)	☐ YES ☐ NO	Undergone a pill cam procedure	☐ YES ☐ NO
Heart valve prosthesis	☐ YES ☐ NO	Breathing problem or motion disorder	☐ YES ☐ NO
Eyelid spring or wire	☐ YES ☐ NO	Other implant	☐ YES ☐ NO
Artificial or prosthetic limb	☐ YES ☐ NO	If YES, please list	
Metallic stent, filter, or coil	☐ YES ☐ NO	_____	
Shunt (spinal or intraventricular)	☐ YES ☐ NO	_____	
Vascular access port and/or catheter	☐ YES ☐ NO	_____	
Radiation seeds or implants	☐ YES ☐ NO	_____	

Please list your previous surgery _____

What are your symptoms? _____

Your doctor has recommended that you use Quantum Radiology. You may choose another provider but please discuss this with your doctor first.



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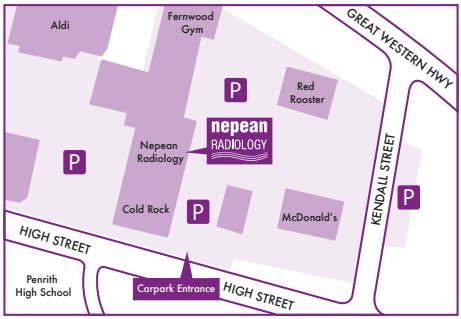
OFFICE HOURS
Monday to Friday 8.00am - 5.00pm
Saturday 8:30am - 12:30pm



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