

PATIENT DETAILS

Name: _____ Date of birth: _____
Address: _____ Telephone (H): _____
Telephone (B): _____
Med. No.: _____

REQUEST/REFERRAL FOR:

CLINICAL DETAILS:

58 year old with chronic pericarditis diagnosed retrospectively, associated with Pfizer vaccine (x1); pain settled with colchicine, but residual orthopnoea.

Need to exclude intramyocardial scarring (vaccine-associated myocarditis); also please assess pericardial thickness/constriction.

☐ MRI

MRI HEAD

☐ Brain ☐ Skull base ☐ Orbits
☐ Pituitary ☐ IAM ☐ Other _____

MRI SPINE

☐ Cervical Spine ☐ Thoracic Spine
☐ Lumbosacral Spine ☐ Other _____

MRI ☐ Other Body Region _____

IMPORTANT:

Indicate whether the following applies to your patient.

☐ Pre-MRI safety x-ray Orbits / Skull / CXR

History of welding, grinding, sheet metal work Yes ☐ No ☐

Cardiac pacemaker Yes ☐ No ☐

Brain aneurysm clip Yes ☐ No ☐

Cochlear implant Yes ☐ No ☐

☐ CT Scanning

If Diabetic, does treatment contain Metformin

Yes ☐ No ☐

What is current renal function?

Date of renal function?

Sex: Male ☐ Female ☐ Is the patient pregnant? Yes ☐ No ☐

REFERRING DOCTOR DETAILS:

PATIENT CATEGORY:

RESULTS:

☐ PTE ☐ Vet/Aff ☐ Telephone report (No. _____)
☐ W/C ☐ TAC ☐ Films & report return with patient
☐ Pension ☐ Facsimile report (No. _____)

COPIES TO:

DOCTOR'S SIGNATURE:



DATE:

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*subject to patient preparation requirements and availability

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Date: _____

Clinic: _____

Address: _____

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