

| | HOSPITAL UR | DATE OF BIRTH / | / |
|--|------------------------------------|---|---|
| Medical Imaging Referral | AFFIX PATIENT LABEL HERE ↑ | | |
| Patient/parent please inform Medical Imaging taff if patient details are incorrect | Print patient's name if label used | | |
| xamination required (including sedation, general anaesthetic or play therapy) | Patient location O O | Outpatient Vard: Room/cubicle number | |
| | | o Yes, please specify | |
| | Consultant | | |
| leason for examination and relevant past history | Referring doctor, if different | | |
| | Signature | | |
| | Pager number | Date / | / |
| | Provider number | | |
| | Imaging Technologist | t Use | |
| | ○ Positive ID ○ Pre | egnancy check MIT/NMT initials | _ |
| | Allergy O No O | Yes, please specify | |
| | Renal failure O Yes | O No Number of images | |

NAME

ADDRESS



Appointments - Monday to Friday

| General enquiries | All preparation details are listed on the appointment letter. | |
|---|--|--|
| CT Scan | For information on preparing children for their imaging visit | |
| General Radiography (X-ray) | and the types of medical imaging examinations, refer to | |
| Fluoroscopy (e.g. barium meal or swallow) | www.rch.org.au/med_imaging Additional information/technical notes | |
| Nuclear Medicine | | |
| Ultrasound | | |
| TELEPHONE (03) 9345 5255 FACSIMILE (03) 9345 6694 HOURS 8.00AM TO 5.00PM | | |
| MRI | | |
| TELEPHONE (03) 9345 4301 FACSIMILE (03) 9345 4325 HOURS 7.45AM TO 8.00PM | | |
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Medical Imaging

The Royal Children's Hospital Melbourne East Building, Lower Ground (Underwater) 50 Flemington Road Parkville Victoria 3052 Australia