Medical Imaging
Lower Ground – Underwater
50 Flemington Road
Parkville Victoria 3052 Australia
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E medical.imaging@rch.org.au
www.rch.org.au/med_imaging

The Royal Children's Hospital Melbourne

RESEARCH REQUEST FOR PATIENT IMAGING

1. REQUESTOR:

First name: _____ Surname: _____

Address: _____

Telephone: _____ Pager No: _____ Fax: _____

Hospital/Organisation: _____ Ethics Research/Audit No: _____

Signed: _____ Date: _____

2. INFORMATION REQUESTED:

All patient imaging will be anonymised

UR Number	Exam No / Examination required	Date Examined	Report Required – Yes or No
TOTAL			

Fees: $20 each CD/DVD

Department to be charged:	Cost Centre:
Department Head Authorisation: Name:	Department Head Signature:

3. APPLICANT'S SIGNATURE: _____

DATE: _____

I certify that to the best of my knowledge that the above details are correct