INVASIVE PROCEDURE REQUEST FORM - MEDICAL IMAGING

Queensland Government

Royal Brisbane and Women's Hospital
Level 3, Ned Hanlon Building, Herston 4029
Phone: 3646 2606

Reset Form

Metro North Hospital and Health Service

Print Form

Patient information sheets available at www.qheps.health.qld.gov.au/consent

UR..... ☐ Female ☐ Male ☐ Indeterminate

Family Name.....

Given Names.....

DOB...../...../.....

Home address.....

Phone Nos.....

☐ Inpatient
☐ Outpatient
☐ Bulk Bill

Ward.....
Bed No.....
Clinic.....

☐ Routine
Date required by.....

☐ Urgent
0830 to 1630 Normal week days:
Duty Registrar 73834
Other times:
DEM Registrar 61056
(If necessary: Angio / Fluoro – 63645)

Procedure requested

RADIOLOGY FINAL CHECK	**YES**
Patient identification verified	☐
Procedure & consent verified	☐
Correct side & site verified	☐
Correct patient data & side markers	☐

Patient condition
Is the patient alert and co-operative? ☐ Yes ☐ No GCS.....
Can the patient give informed consent? ☐ Yes ☐ No

Radiographer/Team Leader
Signature.....

Clinical Details
Pregnant? ☐ Yes ☐ No
Infectious? ☐ Yes ☐ No
Allergies? ☐ Yes ☐ No
Specify.....

Risk factors for CT & Angiography

☐ **Nil or**
- ☐ >70 years
- ☐ Hx renal insufficiency
- ☐ Diabetic ☐ On Metformin

If yes to any of the above, must complete
eGFR.....

Bleeding Risk Assessment - MUST be completed

☐ **Nil or**
- ☐ Patient or Family history of severe bleeding post surgery or trauma
  (Epistaxis, gum bleeds, blood in urine or stool, post partum bleeding are NOT risk factors.)

Recent history of the following:
- ☐ Known coagulopathy ☐ Chemotherapy
- ☐ Haematology patient ☐ Liver disease
- ☐ Severe trauma/sepsis ☐ Severe malnutrition

If YES to any of the above: Coag profile and FBC to be completed

Pathology form for biopsy or aspiration completed and attached? ☐ Yes

Blood Results (if required)
Date taken.....
INR..... APTT.....
Plts..... Hb.....

Antithrombotic drugs ☐ Nil

Antiplatelet	Anticoagulant	
☐ Aspirin	☐ Heparin	☐ Dabigatran "Pradaxa"
☐ Clopidogrel "Plavix" "Iscover"	☐ Clexane	☐ Rivaroxaban "Xarelto"
☐ Prasugrel	☐ Warfarin "Coumadin" "Marevan"	☐ Apixaban "Eliquis"
☐ Ticagrelor	☐ Other.....	☐ Other.....
☐ Other.....		

Antithrombotic Drug ceased: ☐ Yes ☐ No
Date and time last given.....

Requested by (PRINT)..... **Consultant Name (PRINT)**..... ☐ **Bulk Bill**
Signature..... **Pager/phone**..... **Date**.....

RADIOLOGIST TO COMPLETE

Radiologist discussed with
Signed Pager Number

Radiologist performing procedure
Signed Pager Number

Comments/notes (eg sedation required)

BOOKING

Clinical pathway commenced? ☐ YES ☐ NO ☐ N/A
Bed required? ☐ YES ☐ NO
Circle: Day bed Post bed Pre & post bed
Where is patient to recover?
Bed arranged by

Date Time
Room
Scheduled by

Notice to the patient. For Medicare eligible examinations only: Your referrer has recommended that you use Queensland Health.
You may choose another provider but please discuss this with your referrer first.