WOMEN'S IMAGING REQUEST

Queensland Government

Royal Brisbane and Women's Hospital
Level 3, Ned Hanlon Building, Herston 4029
Phone: 3646 2606 Fax: (07) 3646 5379

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 Ward.....
☐ Outpatient Clinic.....
☐ Bulk Bill

☐ Routine
☐ Within..... weeks

☐ Urgent
(*Must arrange with Specialist*)
☐ Next OPD appt ...../...../.....

EXAMINATION REQUESTED

Obstetric Ultrasound

- ☐ Ist Trimester Viability / Dating Scan
- ☐ 11 Wk 4 Day - 13 Wk 6 Day Nuchal Translucency +/- Karyotype
  - ☐ First Trimester Serum Screening
  - (GP to arrange this 5 days prior to U/S) ☐ Hosp. ☐ QML ☐ S+N
- ☐ 18-20 Wk Morphology Scan
- ☐ Growth & Well-Being Scan
- ☐ Multiple pregnancy growth scan
- ☐ Cervical Length screening ☐ Frequency.....

Gynaecology

- ☐ TV Scan ☐ TV consented ☐ yes ☐ No
- ☐ Ultrasound Pelvis
- ☐ Saline sonohysterogram (day 10 of cycle)
- ☐ Hysterosalpingogram (HSG) day 10 (X-ray)

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

Sonographer/Radiographer

Signature.....

General Ultrasound

☐ Abdomen ☐ Renal

Neonatal Ultrasound

☐ Cranium ☐ Abdomen
☐ Renal ☐ Hips

Fetal MRI / **complete general imaging blue request form for MRI**

CLINICAL DETAILS

☐ No clinical concerns. Routine follow-up

or This imaging is needed to (tick one and explain)

☐ Confirm ☐ Exclude ☐ Define ☐ Progress of

G ..... P ..... M ..... E ..... T .....

LNMP: ..... EDD: .....

Current BMI.....

Imaging pathway for BMI>40
1. Nuchal scan (11w4d-13w6d)
2. TV scan (14-16w)
3. Morphology scan (22w)
4. Growth scan if necessary (28 or 34w)

Radiologist protocol /Initial.....

Radiographers comments

Requested by ..... Consultant ..... ☐ Bulk Bill

Pager/Phone ..... Provider No .....

Signature ..... Date .....

Time .....

Date .....

Room .....

Initials .....

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.

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