

# ED COVID RISK ASSESSMENT STAMP

Check Patient ID and Affix Label

Clinic:	First Name	Age:
Next Outpatient Appt:	Address	Weight:
<input type="checkbox"/> Inpatient Ward:	Date of Birth:	Sex M / F / Other
		Language:
I certify that this is the correct patient ID sticker:		(referrer's signature)
The form will be returned if not complete		
<b>Imaging Requested</b>		
<input type="checkbox"/> Urgent <input type="checkbox"/> Semi <input type="checkbox"/> Elective		
Clinical Details: (include relevant surgery, imaging and pathology results)		
Pregnant? <input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Previous images in private?
		Name of provider: _____
<b>COVID RISK ASSESSMENT</b>		
Please circle		
<b>CONFIRMED</b> <small>Tested Positive</small>	<b>SUSPECTED</b> <small>Meets current case definition</small>	<b>ILI SYMPTOMS</b> <small>Does not meet current COVID case definition</small>
<b>NOT AN ILI</b> <small>Influenza like illness</small>		
Risk factors for Medical Imaging: <input type="checkbox"/> NIL   OR		
<input type="checkbox"/> > 60 yrs <input type="checkbox"/> Hx renal insufficiency		
<input type="checkbox"/> Diabetic <input type="checkbox"/> on nephrotoxic drugs <input type="checkbox"/> Allergies   Specify: _____		
Creatinine: _____   eGFR: _____   Date tested: _____		
<input type="checkbox"/> Previous reaction to contrast. Details: _____		
<b>OBLIGATORY MRI QUESTIONNAIRE</b>		
Pacemaker/wires <input type="checkbox"/> Y <input type="checkbox"/> N   Metal in eyes <input type="checkbox"/> Y <input type="checkbox"/> N		
Aneurysm clip <input type="checkbox"/> Y <input type="checkbox"/> N   Programmable shunt <input type="checkbox"/> Y <input type="checkbox"/> N   Able to lie flat <input type="checkbox"/> Y <input type="checkbox"/> N		
Embolisation coils <input type="checkbox"/> Y <input type="checkbox"/> N   Neuro/biostimulator <input type="checkbox"/> Y <input type="checkbox"/> N   Inner ear implant <input type="checkbox"/> Y <input type="checkbox"/> N		
I have considered the risks, including radiation, of this investigation and believe they are justified by the potential benefit to the patient.		
Requested by: _____	Provider N°: _____	Consultant's Name: _____
	Pager/Phone: _____	Consultant's Signature: _____

DO NOT WRITE IN BINDING MARGIN

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