

ED COVID
STAMP

Check Patient ID and Affix Label

Clinic: _____ Next Outpatient Appt: _____ <input type="checkbox"/> Inpatient Ward: _____	First Name: _____ Address: _____ Date of Birth: _____	Weight: _____ Interpreter: <input type="checkbox"/> Y <input type="checkbox"/> N Language: _____	Sex M / F / Other: _____
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I certify that this is the correct patient ID sticker: _____ (referrer's signature)
 The form will be returned if not complete

Imaging Requested

Urgent Semi Elective

Clinical Details: (include relevant surgery, imaging and pathology results) Previous images in private?

Pregnant? Y N

Name of provider: _____

COVID RISK ASSESSMENT

Please circle

CONFIRMED OR SUSPECTED <small>Tested positive or meets current suspected case definition</small>	NOT COVID <small>COVID not considered a realistic differential</small>
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Risk factors for Medical Imaging: NIL OR

> 60 yrs Hx renal insufficiency

Diabetic on nephrotoxic drugs Allergies Specify: _____

Creatinine: _____	eGFR: _____	Date tested: _____
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Previous reaction to contrast. Details: _____

OBLIGATORY MRI QUESTIONNAIRE

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
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: _____

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DO NOT WRITE IN BINDING MARGIN