

**RADIOLOGISTS**

- Dr. **Bryan Fain** MBBSCh FFRad(D)SA FRANZCR
- Dr. **Jonathan Seeff** MBChB Amer Board of Rad FRANZCR
- Dr. **Andy Gartagnini** MBBSCh FFRad(D)SA FRANZCR
- Dr. **Guy O'Connell** MBBS FRANZCR ANZPNM
- Dr. **Kit Lam** BSc(Med)(Medal) MBBS (Syd) FRANZCR
- Dr. **Ron Shnier** MBBS FRANZCR
- Dr. **David Rowan** MBBS (Hons) FRANZCR
- Dr. **Luke Baker** MBBS FRANZCR
- Dr. **Peter Spiegel** MBBS DDR (Syd) FRANZCR
- Dr. **Lynette Masters** MBBS FRACP FRANZCR
- Dr. **Faisal Rashid** BSc(Med) MBBS (Syd) FRANZCR
- Dr. **Suresh De Silva** MBBS (Syd) FRANZCR
- Dr. **Peijin Tew** MBBS FRANZCR

**NAME:** ..... **D.O.B.:** .....

**ADDRESS:** .....

**MEDICARE NO.:** .....

- WORKERS COMP
- THIRD PARTY
- CLINICAL RESEARCH
- HOSPITAL INPATIENT

**EXAMINATION REQUIRED**

**CLINICAL NOTES**

**PATIENT SAFETY QUESTIONNAIRE**

Please answer **ALL** of the following questions.

If **'YES'** is answered to any questions, please inform staff when making your appointment.

Please tick relevant box  for YES or NO.

**Patient Weight:**  kg's.

	YES	NO
A Pacemaker?	<input type="checkbox"/> Y	<input type="checkbox"/> N
A Cerebral Aneurysm Clip?	<input type="checkbox"/> Y	<input type="checkbox"/> N
Cardiac Valve Replacement?	<input type="checkbox"/> Y	<input type="checkbox"/> N
Ear Surgery / Cochlear Implants / Hearing Aid?	<input type="checkbox"/> Y	<input type="checkbox"/> N
A Neuro Stimulator?	<input type="checkbox"/> Y	<input type="checkbox"/> N
Any metal fragments in your eye?	<input type="checkbox"/> Y	<input type="checkbox"/> N
Any artificial joints or screws?	<input type="checkbox"/> Y	<input type="checkbox"/> N
Have you done welding or sheet metal work?	<input type="checkbox"/> Y	<input type="checkbox"/> N
Are you pregnant?	<input type="checkbox"/> Y	<input type="checkbox"/> N
Any history of renal impairment or kidney disease?	<input type="checkbox"/> Y	<input type="checkbox"/> N
Have you had any previous surgery?	<input type="checkbox"/> Y	<input type="checkbox"/> N

Please list your previous surgery: .....

What are your symptoms?: .....

Patient Signature: ..... Date: .....

**REPORT** (Please tick)

- Urgent
- Phone result
- Fax
- Copy to

**FILMS**

- Deliver
- Return with Patient
- CD
- More referral forms please

**REFERRING DOCTOR DETAILS**

**DOCTOR'S NAME:** .....

**ADDRESS:** .....

**PROVIDER NO.:** .....

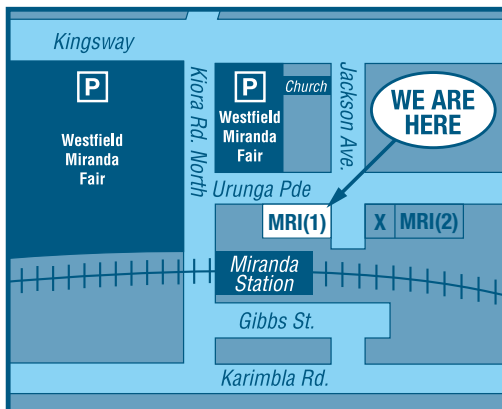
**SIGNATURE:** ..... **DATE:** .....

# ALL MRI EXAMINATIONS REQUIRE APPOINTMENTS

## DIAGNOSTIC MRI SERVICES PRACTICES



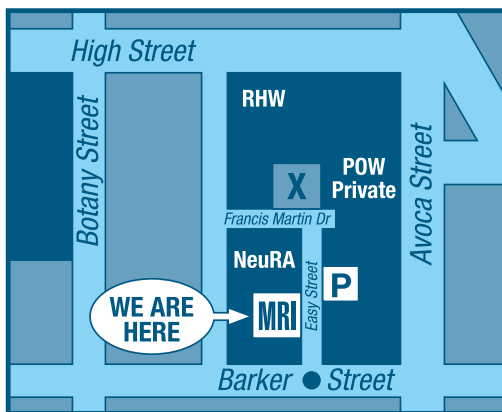
**Camperdown** (Brain & Mind Research Institute)  
Ground Floor, 94 Mallett Street P. 9114 4166



**Miranda MRI(1):** 38-40 Urunga Pde P. 9531 8801



**Miranda MRI(2):** 32-36 Urunga Pde P. 9531 8801



**Randwick** (Neuroscience Research Australia)  
139 Barker Street P. 9399 1200

## OTHER SOUTHERN RADIOLOGY PRACTICES

### Bondi Junction

3 Waverley Street (enter from Hollywood Ave)

### Burwood

36-38 Victoria Street East

### Miranda

32-36 Urunga Parade

### Hurstville Central Shopping Centre

225H Forest Road (carpark level above train station)

### Hurstville Private Hospital

Specialist Medical Clinic, Level 1, 2 Pearl Street

### Menai

Level 1, Menai Market Place, Allison Crescent

### Randwick (Prince of Wales Private Hospital)

Level 7, Suite 27, Barker Street

**PLEASE BRING ALL RELEVANT PRIOR EXAMINATIONS  
TO YOUR APPOINTMENT**