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❑ Radiology Department
Maria Middelares Medical Centre
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appointment at o'clock

REQUEST FORM FOR MEDICAL IMAGING EXAMINATION

A request form is required per clinical indication.

PATIENT IDENTIFICATION:

RX LABEL

PATIENT LABEL / VI STRIP
Last name:
Given name(s):
Date of birth:
Gender: ❑ male / ❑ female

Proposed examination(s): **(mandatory completion)**	Diagnostic inquiry: **(mandatory completion)**
Previous relevant examination(s) related to the diagnostic question: **(mandatory completion)** ❑ CT ❑ NMR ❑ RX ❑ Ultrasound ❑ Other: ..... ❑ Unknown	Relevant clinical information: **(mandatory completion)**
Mandatory information from the requesting physician for contrast imaging studies	**Required questionnaire for the patient and/or requesting physician for contrast imaging studies**
Indicate, if applicable: ❑ Renal function: (e)GFR > 60 ❑ Renal function: (e)GFR < 60 ❑ Allergies If requesting drainage, a puncture, angiography or a biopsy: check the coagulation parameters prior to the examination.	Indicate, if applicable: ❑ Already undergone a similar examination with contrast agent? ❑ Ever had an allergic reaction to contrast agent? ❑ Do you suffer from allergies and/or take medication for them? ❑ Do you have asthma? ❑ Do you suffer from Kahler's disease? ❑ Do you have diabetes? If so, do you take pills for this? ❑ Do you have a thyroid problem? ❑ Do you have serious heart disease? ❑ Are your kidneys functioning less effectively? ❑ Could you be pregnant or are you currently breastfeeding? ❑ Other relevant additional information: ..... **If you undergo NMR, complete the reverse side also!**
Important notes Indicate, if applicable: ❑ Contamination risk: ❑ Patient isolation: ❑ Patient transport: ❑ on foot ❑ wheelchair ❑ bed ❑ Bedside radiographic examination ❑ Possible pregnancy ❑ Nothing by mouth	
Requester's signature: (stamp with last name, first name, address, RIZIV no.) Date:	Patient's signature: Date:

This request form is only eligible for reimbursement by RIZIV if all sections are correctly filled in by the requesting physician, see. ZIV Act article 22. If not, the normal processing of the requested examination may be delayed. If unable to attend, please cancel the appointment at least 48 hours in advance using the above numbers; otherwise, an administrative fee will be charged.

You can find this form on the intranet or at www.mariamiddelares.be and choose 'Download and media centre', 'GPs'. Download the form 'Request for Medical Imaging Examination' .

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You will immediately enter a strong magnetic field. This is perfectly safe provided that you fill in the questions below completely and leave all metal or magnetic objects (watch, mobile phone, bank cards, keys, wallet, bra, etc.) in the dressing room.

NMR - questionnaire

► What is your:

► **HEIGHT:**. ..... **cm** ► **WEIGHT:**. ..... **kg**

► Do you have (or have you):

► a pacemaker? } Able to present card with serial number and type? ❑ Yes ❑ No

► a defibrillator? ❑ Yes ❑ No

► a heart valve? ❑ Yes ❑ No

► a middle ear implant (cochlear implant)? ❑ Yes ❑ No

► a hearing aid? ❑ Yes ❑ No

► a neurostimulator, pain pump or insulin pump? ❑ Yes ❑ No

► a diabetes sensor (FreeStyle Libre 14 day)? ❑ Yes ❑ No

► a tattoo, permanent make-up or a piercing? ❑ Yes ❑ No

► undergone an aneurysm clip or surgery on a blood vessel in brain? ❑ Yes ❑ No

► any orthopaedic materials (prosthesis, screws, etcetera) or implants? ❑ Yes ❑ No

► a metal object in the eye (or are you a metal worker)? ❑ Yes ❑ No

► a removable dental prosthesis or other protheses? ❑ Yes ❑ No

► claustrophobia? ❑ Yes ❑ No

► a history of cancer? ❑ Yes ❑ No

► If you are undergoing a back, neck or knee MRI:

► Have you previously undergone surgery in the area being examined? ❑ Yes ❑ No

If yes: when: .....

► If you are in pain: ❑ Left ❑ Right

► Have you recently had an accident or suffered a sports trauma? ❑ Yes ❑ No

► For female patients:

► Are you (possibly) pregnant? ❑ Yes ❑ No

► Are you breastfeeding? ❑ Yes ❑ No

► If you are undergoing a breast or a MAMMO MRI:

► Have you already undergone breast surgery? ❑ Yes ❑ No

If yes: ❑ Left ❑ Right

► Are you taking hormonal medications? ❑ Yes ❑ No

► Date of last menstrual period: .....

This examination is important for determining the next steps in your care. During regular working hours (8AM-6PM; Mon-Fri), we can perform this examination at the standard rates, with the personal responsibility portion equal to the co-payment. Outside these working hours and on weekends, the personal responsibility portion is higher (€45.00).

Name: ..... Signature:

Date: …… / …… / ……....