

**CARDIOVASCULAR MRI  
Radiology Referral**

Book online at: [wradi.com.au](http://wradi.com.au)

Email to: [cardiacimaging@wradi.com.au](mailto:cardiacimaging@wradi.com.au)

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Telephone: \_\_\_\_\_

**INDICATIONS:**

- |   |  |
|---|--|
| <input type="checkbox"/> Heart failure ?cause                 | <input type="checkbox"/> Viability assessment                |
| <input type="checkbox"/> CMR alone                            | <input type="checkbox"/> Pericardial assessment              |
| <input type="checkbox"/> CMR + HRCT (full sarcoid assessment) | <input type="checkbox"/> ?ARVD / RV assessment               |
| <input type="checkbox"/> CMR + CTCA                           | <input type="checkbox"/> Aortic valve assessment             |
| <input type="checkbox"/> LV hypertrophy ?cause                | <input type="checkbox"/> Aorta assessment                    |
| <input type="checkbox"/> MINOCA ?cause                        | <input type="checkbox"/> Shunt /ASD /VSD /simple congenital* |
| <input type="checkbox"/> Arrhythmia / VE's ?cause             | <input type="checkbox"/> Complex congenital assessment*      |
| <input type="checkbox"/> Cardiac mass ?cause                  | <input type="checkbox"/> Other (please state below)          |

\* For congenital studies, please indicate your preferred reporting cardiologist

Clinical History: \_\_\_\_\_

eGFR..... Creatinine..... Allergies..... Claustrophobia? Y / N

Metal foreign body Y / N (if yes, please specify) .....

Referrer: \_\_\_\_\_

Signature: \_\_\_\_\_

Appointment and Enquiries: **Telephone: (08) 9200 2777**  
**Facsimile: (08) 9200 2778**

Provider No: \_\_\_\_\_ Date: \_\_\_\_\_

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	MRI	CT Scan	Ultrasound	Digital X-Ray	Coronary Angio & Calcium Score	OPG	DEXA	Intervention
<b>BALCATT</b> 275 Wanneroo Road, Balcatta 6021		●	●	●	●	●	●	●
<b>CANNING VALE</b> 1/410 Ranford Rd, Canning Vale 6155	●	●	●	●	●	●	●	●
<b>CLAREMONT</b> 1/278 Stirling Highway, Claremont 6010		●	●	●	●	●	●	●
<b>CLARKSON</b> 10/61 Key Largo Dr, Clarkson 6030		●	●	●	●	●	●	●
<b>COCKBURN</b> 2/810 North Lake Rd, Cockburn 6164		●	●	●	●	●		●
<b>MADELEY</b> 1/210 Wanneroo Rd, Madeley 6065	●	●	●	●	●	●	●	●
<b>MANDURAH</b> 73-77 Reserve Dr, Mandurah 6210		●	●	●	●	●	●	●
<b>MORLEY</b> 133 Russell St, Morley 6062	●	●	●	●	●	●	●	●

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## Patient Preparation Instructions

### ABDOMEN ULTRASOUND:

Patients are required to fast for a minimum of 6-8 hours. Please do not smoke, consume dairy or chew gum during fasting. You may drink fluids such as water, black tea or black coffee only. Consume no sugar or sweeteners and take medications as normal.

### MRI:

Patients are required to remove all jewellery including piercings prior to the examination and ideally should leave jewellery at home.

### PELVIC ULTRASOUND:

Patients are required to have a full bladder, and must finish drinking 1 litre of water 1 hour prior to their appointment time and hold (do not go to the toilet).

### RENAL (KUB) ULTRASOUND:

Patients are required to fast for a minimum of 6-8 hours. Please do not smoke, consume dairy or chew gum during fasting. Patients ALSO require a full bladder, and must finish drinking 1 litre of water 1 hour prior to their appointment and hold (do not go to the toilet). You may drink fluids such as water, black tea or black coffee only. Consume no sugar or sweeteners and take medications as normal.

Your referrer has recommended you use Western Radiology. You may select another provider but please discuss this with referrer first.

Facsimile: (08) 9200 2778 Email: [reception@wradi.com.au](mailto:reception@wradi.com.au) Book online at: [wradi.com.au](http://wradi.com.au)