



Name

DOB

Address

Sex

Medicare No

Phone

### Diagnostic Request Diagnostic Services Requested

**Item 63541** (\*only payable once per patient every 12 months)

- ☐ a digital rectal examination is suspicious for prostate cancer
- ☐ under 70 years old; two PSA tests (prostate specific antigen) performed within 1-3 months; PSA both > 3.0 ng/ml; and free/total PSA ratio < 25%, or repeat PSA >5.5 ng/ml
- ☐ under 70 years old; risk based on family history is double the average risk (\*1st degree relative with prostate cancer or BRCA1, BRCA2 mutation); two PSA tests performed within 1-3 months; both > 2.0 ng/ml, and free/total PSA ratio < 25%
- ☐ 70 years old and over; two PSA tests performed within 1-3 months; both > 5.5 ng/ml and free/total PSA ratio < 25%

**Item 63543** ( The Medicare guidelines - a period of at least 12 months needs to have elapsed before benefits for a second service under 63543 are payable. Benefits are then only payable after a period of three years has elapsed from the date of the second scan and at least each three years thereafter)

- ☐ the patient is under active surveillance following confirmed diagnosis of prostate cancer by biopsy histopathology and the patient is NOT planning or undergoing treatment for prostate cancer

**No item number**

- ☐ MRI Prostate (no rebate) – does not meet eligible Medicare criteria

### Referral Details Reason for Referral and Clinical History

eGFR ..... Date .....

PSA 1 ..... Date .....

PSA 2 ..... Date .....

### Referring Practitioner's Details (include Practitioner's name and provider number)

Signature

Copy to

### MRI +/- Orbits +/- Skull +/- Chest X-ray

**IMPORTANT:** Indicate whether the following applies to your patient.

- ☐ Y ☐ N History of welding, grinding, sheet metal work
- ☐ Y ☐ N Cardiac pacemaker
- ☐ Y ☐ N Brain aneurysm clip
- ☐ Y ☐ N Cochlear implant
- ☐ Y ☐ N CT Scanning

### Internal use only

☐ Y ☐ N Pregnant

☐ Y Patient identification verified

☐ Y Procedure and consent verified

Tech name/position:

### CT scanning

☐ Y ☐ N If Diabetic, does treatment contain Metformin?

What is current renal function?

Date of renal function?

Most recent eGFR?

### Referring Clinical use only

☐ Telephone report ( \_\_\_\_\_ )

☐ Films with patient

Thank you for referring your patient to Epworth Medical Imaging



# Radiology Request

## My Appointment

Time

Other

Your doctor has recommended you use Epworth Medical Imaging. You may choose another provider but please discuss this with your doctor first.

[illegible]