

Name

DOB

Address

Sex

Phone

Medicare No

Diagnostic Request
Diagnostic Services Requested

Referral Details
Reason for Referral and Clinical History

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

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

CT scanning

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

What is current renal function?

Date of renal function?

Most recent eGFR?

Internal use only

☐ Y ☐ N Pregnant

☐ Y Patient identification verified

☐ Y Procedure and consent verified

Tech name/position:

Referring Clinical use only

☐ Telephone report (_____)

☐ Films with patient

Thank you for referring your patient to Epworth Medical Imaging



My Appointment

Time

Location

Other

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

[illegible]