CARDIAC IMAGING REQUEST

www.heartvision.co.nz

Phone: 03 379 0770 FAX: 366 7414

Patient Details:

Patients Name: D.O.B. NHI:

Address: Phone: Funding:

Email: Scan Urgency:

Examination Required – tick ALL that apply

MRI Cardiac ☐ Christchurch ☐ Dunedin

CT (Christchurch ONLY) ☐ Calcium Score ☐ Coronary Angiogram ☐ TAVI

Clinical Details:

CHECK-LIST - Please complete as required for ALL Patients

All Patients: WEIGHT: HEIGHT:

MRI ONLY ☐ Cerebral Aneurysm Clip ☐ Intra-Orbital FB

☐ Neuro-electrical Stimulator ☐ Heart Pacemaker

eGFR: Date: Hct: Date:

CT Coronary Angiogram ONLY ☐ Coronary Stents or CABG Details:

Resting Heat Rate: eGFR: Date:

Please prescribe β-Blocker and GTN spray for CTCA (NOT REQUIRED IF TAVI ONLY), it is the referring clinicians responsibility to screen for contra-indications. Prescribed drugs will be administered by Radiology Staff on the day of the scan according to the CTA β-Blocker/GTN protocol

Is the Patient taking a β-Blocker? ☐ Yes ☐ No Does the patient use GTN Spray? ☐ Yes ☐ No

Contraindication to β-Blocker? ☐ Yes ☐ No Contraindication to GTN Spray? ☐ Yes ☐ No

Is the Patient taking a Ca Channel Blocker? ☐ Yes ☐ No

Drug and Dose	**Prescribing Dr Signature**	**Prescribing Dr Print Name and MCNZ Number**
Metoprolol 100mg PO stat		
Additional Metoprolol 50mg PO PRN		
GTN 1 spray S/L prior to scan		

Referrer:

Referrer Name: Signature:

Copy to: Date: