Cardiac Imaging Referral

Mater Private Network

Email to: **cardiacimaging@materprivate.ie**

PATIENT DETAILS

Name:

Address:

Date of Birth: **Telephone:**

Mater Private MRN (if known)**:**

Gender:

Infection Risk:

Scan Urgency: Urgent Soon Routine

Exam Required:

Clinical Indication:

Prior PCI or CABG	Yes	No
History of acute severe asthma / reactive airway disease	Yes	No
Iodine contrast allergy	Yes	No
Gadolinium contrast allergy	Yes	No
Pacemaker / implantable loop recorder / valve replacement	Yes	No

REFERRING CLINICIAN DETAILS

Name (PRINT):

Medical Council Number

Date: Signature:

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www.materprivate.ie