

Interventional Checklist

To be completed by referrer or healthcare professional

Benson Radiology – Ashford Clinic

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**Biopsies/Drains to be sent straight to the email address above along with the questionnaire below. **

Referrer details

Name:

Contact person:

Contact number:

Patient details

Full Name:

Date of Birth:

Questionnaire

Admitting Rights at Ashford Hospital?

Yes / No

Does the patient hold Private Health Insurance?

Yes / No

Ideal time frame for procedure to be completed by?

Prior imaging

Has there been any prior imaging for the requested procedure?

Yes / No

If yes, please provide details of any prior relevant imaging:

Coagulation studies (INR, APTT & platelets)

Have coagulation studies/platelets been performed?

Yes / No

If yes, please provide details below:

Date of when this was completed.

...../...../.....

Pathology Company used.

Anticoagulation medication

Is the patient using anticoagulation medication?

Yes / No

Name of anticoagulation medication?

Who was the authorizing doctor?