CABRINI MEDICAL IMAGING

BH T: 03 9508 1338
F: 03 9508 1896

AH T: 03 9508 1920
F: 03 9508 8556

MEDICAL IMAGING EXCHANGE (MIX)
HUB AND SPOKE TRANSFER

Please tick one: ☐ **REQUESTING** images from other hospital ☐ **NOTIFICATION** of sending images to other hospital

Urgent? (please circle) **Yes** **No**	**Requesting Unit:**	**Person completing this form**	
Date images needed by:		Name	Phone

***Minimum of three patient identifiers required: Name, DOB and one other**	Patient name:				
	Patient DOB:				
	Patient address:				
	Hospital UR/Folio no:				
	Medicare number:				
Studies requested/sent	Study date:				
	Modality:				
	No. of images:				

REQUESTING IMAGES FROM: (please circle)				**SEND IMAGES TO:** (please circle)			
Alfred	Amb Vic	Austin	Ballarat	Alfred	Amb Vic	Austin	Ballarat
Barwon	Bendigo	Breast Screen	Cabrini	Barwon	Bendigo	Breast Screen	Cabrini
Darwin	Eastern	Epworth	Future MIG	Darwin	Eastern	Epworth	Future MIG
Lake Imaging	Monash	Northern	Peninsula	Lake Imaging	Monash	Northern	Peninsula
PMCC	RCH	RMH	St. Vincent's	PMCC	RCH	RMH	St. Vincent's
Tasmania	Western	Western Priv	Women's	Tasmania	Western	Western Priv	Women's

Report to be faxed? (please circle) **Yes** **No** Fax no (if different):

Clinical reason for needing the images transferred?

AUTHORITY TO TRANSFER: ONE OF THE OPTIONS BELOW IS REQUIRED

Cabrini clinician providing primary clinical management OR requiring consultation to provide ongoing clinical care for the named patient?

☐ **Yes**

Clinician name

Signature

Named patient has given permission for their medical images to be stored at the destination hospital?

☐ **Yes**

Clinician name

Signature

Requesting clinician at the destination hospital requiring images?

☐ **Yes**

Clinician name

Signature

FOR RADIOLOGY STAFF TO COMPLETE: Date:

Name and signature of staff member sending/receiving images:

Cabrini MEDICAL IMAGING