Medical Image Exchange (MIX)
Digital Image Transfer Request / Notification Form

☐ REQUESTING images from other Hospital

☐ NOTIFICATION of sending images to other Hospital

Western Private Hospital
Ph: 03 9304 7314 Fax: 03 9304 7347
email: pacs@westernprivate.com.au

Urgent? ☑ Yes ☐ No (ie. within 24 hrs)	Date/time images needed by:	Date request sent:

** Minimum of 3 Patient Identifiers required; Name, DOB and 1 other **	Patient Name:	
	Patient DOB:	
	Patient Address:	
	WPH UR Number:	
	Other Hosp UR (if known):	

Images From -

☐ Alfred ☐ Amb Vic ☐ Austin ☐ Ballarat ☐ Barwon ☐ Bendigo ☐ Breastscreen ☐ Cabrini
☐ Capital ☐ Darwin ☐ Eastern ☐ Epworth ☐ FMIG ☐ Goulburn Valley Health ☐ i-MED/MIA
☐ Lake Imaging ☐ Monash ☐ Northern ☐ Peninsula ☐ PMCC ☐ RCH ☐ RIS ☐ RMH
☐ St. Vincent's ☐ TAS - Laun ☐ TAS - RHH ☐ Western ☐ West Priv. ☐ Womens ☐ Other: _____

Send Images To -

☐ Alfred ☐ Amb Vic ☐ Austin ☐ Ballarat ☐ Barwon ☐ Bendigo ☐ Breastscreen ☐ Cabrini
☐ Capital ☐ Darwin ☐ Eastern ☐ Epworth ☐ FMIG ☐ Goulburn Valley Health ☐ i-MED/MIA
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☐ St. Vincent's ☐ TAS - Laun ☐ TAS - RHH ☐ Western ☐ West Priv. ☐ Womens ☐ Other: _____

Studies to be transferred							
	Study Date						
	Modality						
	Region						
	No. of images						

Report to be faxed? ☑ Yes ☐ No Fax no if different _____

Clinical Reason for needing the images transferred? _____

CLINICIAN'S CERTIFICATION

I certify that the images requested are relevant to the patient's current treatment and will be used solely for this purpose

Clinician Name _____

Requesting Unit _____

Name of person completing form _____

(if different to clinician name)

Contact no of person completing form _____

(in case there is problem sending/importing - DO NOT LEAVE BLANK)

Comments

FOR RADIOLOGY STAFF TO COMPLETE

Sending hospital to push images then FAX or EMAIL this request to receiving hospital

Fax no. of receiving hospital _____ *Email* _____

Name of PACS person sending images _____ *Contact phone* _____