Spectrum medical imaging

Adrenal Gland, Liver and Pancreas/ Biliary Tree MRI Request Form

**May be Medicare eligible when referred by a Specialist*

Patient details

MRI Adrenal Gland

☐ **Medicare Eligible scan* (please indicate which criteria met)**

☐ Scan of the body for adrenal mass in a patient with a malignancy that is otherwise resectable (R) (Anaes.)(63461)

(Note: Benefits are payable on only one occasion in any 12-month period)

☐ **Non - Medicare eligible scan** **Contrast Agent** ☐ Primovist ☐ Gadovist

MRI Liver

☐ **Medicare Eligible scan* (please indicate which criteria met)**

☐ MRI - multiphase scans of liver (including delayed imaging, if performed) with a contrast agent, for characterisation, or staging where surgical resection or interventional techniques are under consideration if: (63545).

- (a) the patient has a confirmed extra-hepatic primary malignancy (other than hepatocellular carcinoma); and
- (b) computed tomography is negative or inconclusive for hepatic metastatic disease; and
- (c) the identification of liver metastases would change the patient's treatment planning

(Note: Applicable not more than once in a 12 month period (R) (Contrast) (Anaes.)

☐ Known or suspected hepatocellular carcinoma for the purposes of diagnosis or staging (63546).

- The patient has pre-existing chronic liver disease, confirmed by a specialist;; **and**
- Has an identified hepatic lesion over 10mm in diameter; **and**
- Has been assessed as having a Child-Pugh class A or B liver function

(Note: Benefits are payable on only one occasion in any 12-month period)

☐ **Non - Medicare eligible scan** **Contrast Agent** ☐ Primovist ☐ Gadovist

MRI Pancreas/Biliary Tree (MRCP)

☐ **Medicare Eligible scan* (please indicate which criteria met)**

☐ Scan of pancreas and biliary tree for suspected biliary or pancreatic pathology (63482)

(Note: Services for this item number are payable on 3 occasions in a 12-month period)

☐ **Non - Medicare eligible scan** **Contrast Agent** ☐ Primovist ☐ Gadovist

Clinical Notes

Referring Doctor This section **MUST** be completed

Signature: Date: