

18 August 2014

Lachlan Broadribb Coroners Registrar Coroners Court of Victoria Level 11 222 Exhibition St Melbourne VIC 3000

Dear Sir/Madam

RE: Court ref: COR 2010 002497

I write to you in response to the Coroner's findings and recommendations following the investigation into the death of Linda Parker – court reference 2010 002497.

As per the Coroner's recommendation, Regional Imaging is currently in the process of reviewing our radiology request form with a view to redesign to include relevant clinical information of previous caesarean section.

This process is being overseen by the organisation's Clinical Management Committee and is anticipated to be complete by the 30th September 2014.

The new request form will be provided to referrers along with appropriate education that alerts referrers of the need to provide relevant clinical information of previous caesarean section when referring for obstetric ultrasound imaging.

If any further information is required, please don't hesitate to contact me at mark.simpson@regionalimaging.com.au.

Yours sincerely

Mark Simpson General Manager

Regional Imaging

sent via email to: cpuresponses@coronerscourt.vic.gov.au



Δ	Appointments
C	all: 1800 888 669
D	ate:
Ti	ime:
	Cocation: Latrobe Regional Hospital Traralgon Morwell Moe West Gippsland Hospital Maryvale Private Hospital Warragul
I۱	V Contrast Alert
	ontrast Allergy Yes No
	enal Disease Yes No
	iabetes Metformin treatment Yes No
C	reatinine level:
e	GFR:
D	ate:
Λ	/IRI
	dicate whether the following pplies to your patient.
sl	istory of welding, grinding, heet metal work Yes No
C	ardiac pacemaker Yes No
	rain aneurysm clip Yes No
	ochlear implant Yes No
fi	ntravascular coils, Iters, stents Yes \(\) No
C	Obstetric Ultrasound
ln	revious Uterine surgery/ istrumentation) Yes
N	umber:
	ato I MD:

Directions Bone Densitometry Nuclear Medicine for Patients **Mammography** Interventional General X-ray Angiography Fluoroscopy **Ultrasound Practice Procedure** MRI ᇅ List VALLEY DR Latrobe Regional Hospital Princes Highway 1 Traralgon VIC 3844 **Appointments:** 1800 888 669 REGIONAL IMAGING Fax: (03) 5173 8081 REGIONAL IMAGING **Traralgon** 39 Breed St Traralgon VIC 3844 **Appointments:** 1800 888 669 **Fax:** (03) 5173 4211 Morwell 3 - 4 Hoyle St Morwell VIC 3840 **Appointments:** 1800 888 669 REGIONAL IMAGING Fax: (03) 5133 0501 Moe 46 - 48 Albert St Moe VIC 3825 / V ALBERT ST **Appointments: 1800 888 669** REGIONAL Fax: (03) 5127 8975 **IMAGING** PRINCES FWY PRINCES HWY **West Gippsland Hospital** LANDSBOROUGH ST REGIONAL IMAGING Landsborough St Warragul VIC 3820 **Appointments: 1800 888 669** Fax: (03) 5623 0657 ALBERT ST Warragul 52 Albert St ALBERTST REGIONAL IMAGING Warragul VIC 3820 V **Appointments: 1800 888 669** Fax: (03) 5623 0903 ANDREW ST CRINIGAN ROAD BUSHLAND RESERVE **Maryvale Private Hospital** 286 Maryvale Rd, Morwell REGIONAL IMAGING V **Appointments:** 1800 888 669 **Fax:** (03) 5173 8081 CRINIGAN RD CRINIGAN RD

Please note: Some examinations require special preparation. Please check when making your appointment. Patient preparation information can be found at **regionalimaging.com.au**

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	PLEASE BRING PREVIOUS FILMS FOR (COMPARISON		Appointments
		Call: 1800 888 669		
	NAME:		DATE OF BIRTH:	Date:
Patient	ADDRESS:	Time:		
	TELEPHONE (H): TELEPHONE (M): POSSIBILITY OF PREGNANCY? YES	Location: Latrobe Regional Hospital Traralgon Morwell Moe		
Examination Required	O ANGIOGRAPHY O BONE DENSITOMETRY O CT O FLUOROSCOPY REGIONS:	GENERAL X-RAY INTERVENTIONAL PROCEDURES MAMMOGRAPHY MRI	ONUCLEAR MEDICINE OPG ULTRASOUND	West Gippsland Hospital Maryvale Private Hospital Warragul IV Contrast Alert Contrast Allergy Yes No
Examina				Renal Disease Yes No Diabetes Metformin treatment
				Yes No
Referring Doctor Clinical Notes				Creatinine level:
				eGFR:
				Date:
				MRI Indicate whether the following applies to your patient.
				History of welding, grinding, sheet metal work Yes No
				Cardiac pacemaker Yes No
				Brain aneurysm clip O Yes O No
				Cochlear implant Yes No
				Intravascular coils, filters, stents Yes No
				Obstetric Ultrasound
				Previous Uterine surgery/ Instrumentation Yes No
	REFERRER NAME:		PROVIDER NO:	Number:
	REFERRER ADDRESS:		COPY REPORT TO:	Date LMP:
	SIGNATURE:		DATE:	

YOUR DOCTOR HAS RECOMMENDED THAT YOU USE REGIONAL IMAGING. YOU MAY CHOOSE ANOTHER PROVIDER BUT PLEASE DISCUSS THIS WITH YOUR DOCTOR FIRST.

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○ FILM ○ URGENT PHONE REPORT

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