Request form / Referral

QueenslandXRay

Patient Details (Name, Address, DOB, Medicare number)

Date:

Diagnostic Request

Reason for referral and clinical history

Follow-up appointment with Referring Doctor:

Referring Practitioner's Details

Practitioner's Name:

Address:

Signature: _____

Copy to: _____

Thank you for referring your patient to Queensland X-Ray.

Internal Use Only

	Yes	No
Pregnant	☐	☐
Front Office Check	☐	
Patient Identification verified	☐	
Procedure and consent verified	☐	
Correct side and site verified	☐	
Film preference verified	☐	

Correct patient data and side markers

Tech initials: _____

Team leader signature: _____