QueenslandXRay

REQUEST FOR
ELECTRONIC IMAGE TRANSFER

Contact support: 1800 779 977
qxrimagetransfer@sonichealthcare.com.au

** MANDATORY FIELDS*

I certify that the studies requested below are required for the ongoing clinical management of the patient indicated and disclosure of this information is not contrary to their wishes.

AUTHORISATION

Name: *

Department:

Phone: *

Email Address: *

Date Requested:

Date Required:

Signature:
(ONLY REQUIRED IF FORM IS FAXED. NOT REQUIRED IF EMAILED)

PATIENT

Patient Name:

DOB:

Patient ID / MRN:

Hospital:

MANDATORY FOR INBOUND TRANSFERS

Form must be sent to both Queensland X-Ray and the institution where the study was performed.

Make study available in Queensland X-Ray WEB PACS* ☐ Yes ☐ No

Study to be reviewed by:* Dr

IMAGE TRANSFER

Imaging From:* -

Other:

(ORIGINATING SITE – PLEASE CHOOSE CAREFULLY)

Imaging To:* -

Other:

(DESTINATION SITE – PLEASE CHOOSE CAREFULLY)

STUDY DETAILS *(IF KNOWN)*

PROCEDURE NAME	DATE OF EXAM

IMAGE TRANSFER

Please ensure a copy of this form is received by both origin and destination sites.
If this does not occur, the transfer will not take place.

QLD X-Ray All Sites	FAX: 3377 1918	**Redcliffe Hospital**	FAX: 3883 7525	**Redlands Hospital**	FAX: 3488 3181
Townsville Hospital	FAX: 4433 1565	**TPCH**	FAX: 3139 4253	**Rockhampton Hub**	FAX: 4920 6346
RBWH	FAX: 3646 6394	**Mackay Hub**	FAX: 4885 5289	**Logan Hospital**	FAX: 3089 6461
Gold Coast Hub	FAX: 5687 4197	**Cairns Hospital**	FAX: 4226 6719	**Longreach Hub**	FAX: 4658 4739
PAH	FAX: 3176 7357	**Roma Hub**	FAX: 4624 2822	**Ipswich Hospital**	FAX: 3810 1765
Toowoomba Hub	FAX: 4616 6984	**Mater Adults**	FAX: 3163 7050	**Nambour Hub**	FAX: 5202 2155
QCH	FAX: 3068 3009	**Hervey Bay Hub**	FAX: 4325 6796		

PRINT THIS FORM