

Patient Details

Date:

Name:

DOB:

Address:

Medicare No:

Serum Creatinine Level:

eFGR:

Diagnostic Request

Reason for referral and clinical history

Referring Practitioner's Details

Practitioner's Name:

Address:

Date:

Signature: _____

Copy to: _____

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

 For bookings scan here
 qldxray.com.au/book-online

Internal Use Only

	Yes	No
Front Office Check	<input type="checkbox"/>	<input type="checkbox"/>
Pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Patient Identification verified	<input type="checkbox"/>	<input type="checkbox"/>
Procedure and consent verified	<input type="checkbox"/>	<input type="checkbox"/>
Correct side and site verified	<input type="checkbox"/>	<input type="checkbox"/>
Correct patient data and side markers		
Tech initials:	_____	
Team leader signature:	_____	

