

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 all appointments

Ph: 4965 6200

Fax: 4942 7506

Email: mackay@qldxray.com.au

Internal Use Only

	Yes	No
Front Office Check	☐	☐
Pregnant	☐	☐
Patient Identification verified	☐	☐
Procedure and consent verified	☐	☐
Correct side and site verified	☐	☐
Correct patient data and side markers		
Tech initials:	_____	
Team leader signature:	_____	

My Appointment

Date: _____

Time: _____

Location: _____

Other: _____

For more information about your examination please visit qldxray.com.au

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PLAIN X-RAY
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OPG
FLUOROSCOPY
CT SCAN
ULTRASOUND
DUPLEX ULTRASOUND
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MAMMOGRAPHY
NUCLEAR MEDICINE
BONE DENSITOMETRY
MRI

HOSPITAL PRACTICE
MATER PRIVATE HOSPITAL

76 Willetts Road, North Mackay

COMMUNITY PRACTICES
FOURWAYS

96 Nebo Road, West Mackay

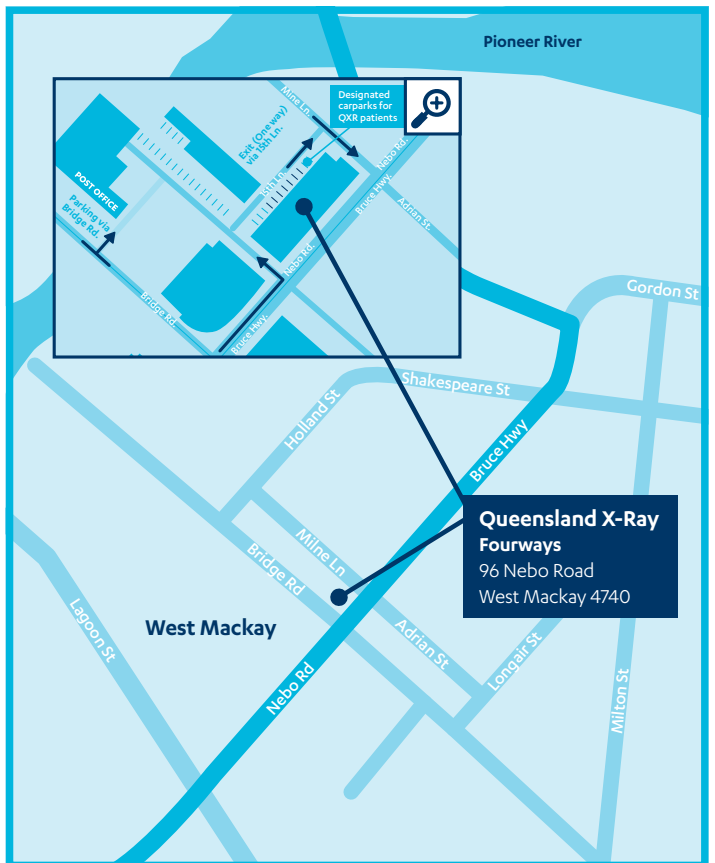
NORTHERN BEACHES

1 Carl Street, Rural View

Ph: 4965 6200

Fax: 4942 7506

MATER PRIVATE HOSPITAL

FOURWAYS

NORTHERN BEACHES


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* Contrast Enhanced Mammography

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