

Patient Details

Date:

Name:

DOB:

Address:

Medicare No:



For bookings
scan here



qldxray.com.au/book-online

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.

Queensland X-Ray Internal Use Only

Medical Imaging Final Check

Yes No

Pregnant

Front Office Check

Patient Identification verified

Procedure and consent verified

Correct side and site verified

Correct patient data and side markers

Tech initials: _____

Team leader signature: _____

