

DOB:

Date: **Patient Details** Name: Address:

Medicare No:

Diagnostic Request

Reason for referral and clinical history

Address:

Referring Practitioner's Details

Signature:

Copy to:

Thank you for referring your patient to Queensland X-Ray

Internal Use Only

Pregnant Front Office Check Patient Identification verified Procedure and consent verified Correct side and site verified

Correct patient data and side markers Tech initials:

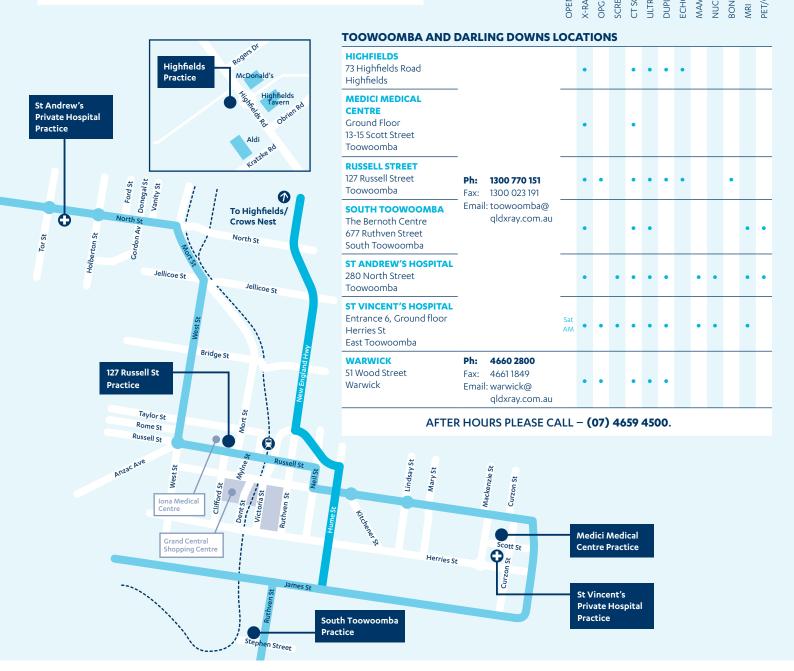
Team leader signature:

Yes No



qldxray.com.au





Access your images and results online. Let our friendly reception staff know you'd like to register for the Patient Portal. For more information, please visit qldxray.com.au/patients/results-portal/

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Your doctor has recommended you use Queensland X-Ray. You may choose another provider but please discuss this with your doctor first.

