

Patient Details (Name, Address,
DOB, Medicare number)

Date:

For bookings
scan hereqldxray.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.

Internal Use Only

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: _____

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

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