

Patient Details

Date:

Name:

DOB:

Address:

Medicare No:

For all appointments

Ph: 4046 7800

Fax: 4051 3028

Email: cairns@qldxray.com.au

Book Online: www.qldxray.com.au

Phone lines open from:

7am-9pm Mon to Fri

8am-4pm Sat & Sun

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: \_\_\_\_\_

