

Patient Details

Date:

Name:

DOB:

Address:

Medicare No:



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Diagnostic Request

Reason for referral and clinical history

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 | <input type="checkbox"/> | <input type="checkbox"/> |
| Front Office Check | <input type="checkbox"/> | <input type="checkbox"/> |
| Patient Identification verified | <input type="checkbox"/> | <input type="checkbox"/> |
| Procedure and consent verified | <input type="checkbox"/> | <input type="checkbox"/> |
| Correct side and site verified | <input type="checkbox"/> | <input type="checkbox"/> |

Correct patient data and side markers Tech initials: _____

Team leader signature: _____



My Appointment

Date: _____

Time: _____

Location: _____

Other: _____

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TOOWOOMBA AND DARLING DOWNS LOCATIONS

HIGHFIELDS

73 Highfields Road
Highfields

MEDICI MEDICAL CENTRE

Ground Floor
13-15 Scott Street
Toowoomba

RUSSELL STREET

127 Russell Street
Toowoomba

SOUTH TOOWOOMBA

The Bernoth Centre
677 Ruthven Street
South Toowoomba

ST ANDREW'S HOSPITAL

280 North Street
Toowoomba

ST VINCENT'S HOSPITAL

Entrance 6, Ground floor
Herries St
East Toowoomba

WARWICK

51 Wood Street
Warwick

Ph: 1300 770 151

Fax: 1300 023 191

Email: toowoomba@qldxray.com.au

Ph: 4660 2800

Fax: 4661 1849

Email: warwick@qldxray.com.au

AFTER HOURS PLEASE CALL – (07) 4659 4500.



Access your images and results online. For more information, please visit <https://www.qldxray.com.au/patients/online-access-patient-portal>

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* Contrast Enhanced Mammography

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