

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

Date:

Diagnostic Request



For bookings
scan here

or call 1300 781 926

Phone lines open from:

7am - 8pm Monday - Friday

7am - 4pm Saturday

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	<input type="checkbox"/>	<input type="checkbox"/>
Front Office Check	<input type="checkbox"/>	
Patient Identification verified	<input type="checkbox"/>	
Procedure and consent verified	<input type="checkbox"/>	
Correct side and site verified	<input type="checkbox"/>	
Correct patient data and side markers		
Tech initials: _____		
Team leader signature: _____		

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

OPEN WEEKENDS
EOS IMAGING
X-RAY
OPC & LATERAL CEPHALOMETRY
FLUOROSCOPY
ANGIOGRAPHY
CT SCAN
ULTRASOUND
ECHOCARDIOGRAPHY
NUCHAL TRANSLUCENCY
MAMMOGRAPHY
NUCLEAR MEDICINE
BONE DENSITOMETRY
PET/CT
MRI

ECF