

Date:

**Request Form can be emailed to
mackay@qldxray.com.au**

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

Dr Andrew McLaughlan
Dr Nitin Sinha
Dr Aileen Cormican

Examination required

Reason for investigation

Practitioner's Name:

Address:

Signature: **Signature Optional**

Copy to:

Thank you for referring your patient to Queensland X-Ray.

Referring Practitioner's Details

Internal Use Only

	Yes	No
Front Office Check	<input type="checkbox"/>	<input type="checkbox"/>
Pregnant	<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:	_____	

