

Imaging Request

Patient Details:

Examination Required:

Clinical Details:

***Please see
back of referral
for directions
and a list of
bulk billed
examinations**

Pregnancy Y/N

Contrast Allergy Y/N

eGFR _____

Referrer Details:

Technologist use only

☐ Patient identification verified

☐ Procedure / consent verified

☐ Site / side verified

☐ Patient data / side markers

Technologist initials: _____

Signature: _____

Images & reports are delivered electronically.

PLEASE CHECK BOX IF FILMS ARE REQUIRED ☐