



REFERRAL AND/OR REQUEST(S) FOR DIAGNOSTIC IMAGING

Low Dose CT | Ultrasound | Digital X-ray | Intervention | OPG

ALL APPOINTMENTS – PHONE: 03 9379 5222

312A Keilor Road,
Essendon North, Victoria 3041
Telephone: 9379 5222 | Fax: 9379 7722
www.niddriexray.com.au

Time of appointment: _____

Date: ____ / ____ / ____

Date of Birth: _____

Phone (H): _____

Medicare No.: _____

Name: _____

Address: _____

EXAMINATION REQUESTED

CLINICAL DETAILS

REFERRER DETAILS

BILLING:

REPORT:

IMAGES:

- Private
- HCC/Pension
- VetAffairs
- WorkCover
- TAC

- URGENT
- Return with Patient
- Post
- Fax
- Email

- CD* Film
- Online access

COPY TO:

ELECTRONIC STORAGE OF IMAGES INDEFINITELY

Doctor's Signature: _____

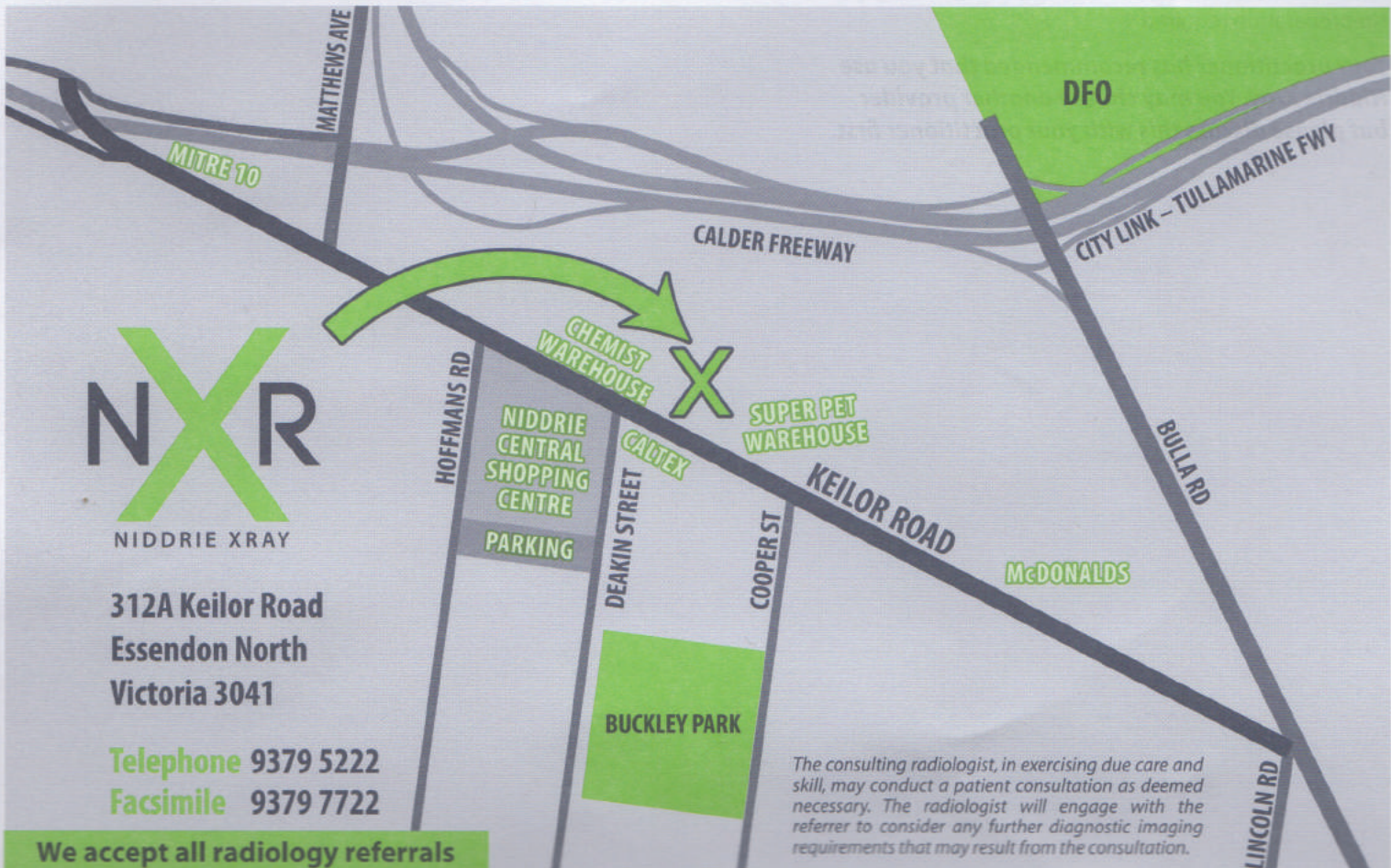
Date: _____

ALERTS

Contrast Allergy Y N Pregnant Y N LNMP _____
 Renal impairment Y N Creatinine _____ eGFR _____ Date _____
 Metformin Y N CT Calcium Score _____

MORE REFERRAL PADS

- A4 loose sheets
- A5



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We accept all radiology referrals

The consulting radiologist, in exercising due care and skill, may conduct a patient consultation as deemed necessary. The radiologist will engage with the referrer to consider any further diagnostic imaging requirements that may result from the consultation.