Victorian Imaging Specialists

Specialist Imaging Request/Referral

Patient Details

Patient Name: _____

Date of Birth: _____ Telephone Number: _____

Address: _____

Medicare: _____ Expiration Date: _____

Examination Required:

- ○ CT-Scan
- ○ MRI
- ○ Ultrasound
- ○ X-ray
- ○ Other: _____

Clinical Notes:

Indicate if ANY of the following apply to your patient:

History of Welding/Grinding:
Yes ○ No ○

Cardiac Pacemaker:
Yes ○ No ○

Cochlear Implant:
Yes ○ No ○

Intravascular coils filters Stents:
Yes ○ No ○

Aneurysm Clip:
Yes ○ No ○

CT Scan

IV Contrast Alert Contrast Allergy:
Yes ○ No ○

Renal Disease:
Yes ○ No ○

Metformin:
Yes ○ No ○

Female: ○

Male: ○

Is the patient pregnant?
Yes ○ No ○

Referrer Name: _____ Provider Number: _____

Referrer Address: _____

_____

Copy Report to: _____

Signature: _____ Date: _____