Austin HEALTH

Department of Molecular Imaging and Therapy

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MOLECULAR IMAGING AND THERAPY REFERRAL FORM
Nuclear Medicine Procedures

When is scan required: _____ Date of next review: _____

Patient Details

Surname _____
First name _____
Date of birth _____
Austin UR _____
Address _____
Suburb _____
Gender ☐ Male ☐ Female

Patient Contact Details

Home phone number _____
Mobile phone number _____
Email address _____
Alternative contact person _____
Phone number _____

Patient status:

☐ Public ☐ DVA
☐ Private ☐ TAC
☐ Overseas patient ☐ Workcare

Referral Information (This form is not to be used for PET scan requests)

Examination required: _____

Clinical notes: _____

Patient mobility requirements: Weight over 150kg? ☐ Requires a hoist lift? ☐

Requesting Doctor & Report Distribution

Referring Doctor _____ Provider No. _____
Mobile _____ Signature _____
Email address _____ Date _____
Preferred mechanism of electronic transfer of report: HealthLink ☐ Medinexus ☐ Other: _____

Additional copy of report to: _____
Email address _____
Preferred mechanism of electronic transfer of report: HealthLink ☐ Medinexus ☐ Other:

Patients are free to take their referral to a diagnostic imaging provider of their choice. Please discuss with your doctor first.
Referral forms may be downloaded from http://www.austin.org.au or internally from The Pulse