Austin Health

Heidelberg Repatriation Hospital

RADIOLOGY REQUEST

FOR APPOINTMENTS PLEASE
CALL: 9496 4163 or FAX: 9496 2456
Monday – Friday 8.30am – 5pm

Name:

Address:

APPOINTMENT TIME:____________________ **DATE:**______________

DATE OF BIRTH:

TELEPHONE (H):

TELEPHONE (B):

MEDICARE No:

HOSPITAL UR No:

REQUEST FOR:

☐ CT Scanning ☐ CT Angiography ☐ Ultrasound ☐ Doppler Ultrasound ☐ Musculo-Skeletal U/S
☐ Mammography ☐ Fluoroscopy ☐ OPG ☐ Lat Ceph ☐ Plain X-Ray

Examination Required:

Clinical Notes:

Signature: Date: / /

- ***Is there a chance the patient may be pregnant?*** ☐ ***Yes*** ☐ ***No***
- ***Is the patient allergic to contrast?*** ☐ ***Yes*** ☐ ***No***
- ***Has the patient had previous relevant imaging examinations?*** ☐ ***Yes*** ☐ ***No***

REQUESTING DOCTOR

NAME:______________________________ PROVIDER No.:__________________

ADDRESS:____________________________________ POSTCODE:__________

PHONE:________________ FACSIMILE:________________ COPY TO:________________

RESULTS: ☐ FILMS & REPORT WITH PATIENT ☐ FAX ☐ MAIL ☐ PHONE

BULK BILLING