



X-Ray & CT Referral Form

Patient Details

Surnames

Given Names

DOB

Email

Address

Phone / Mobile Number

Medicare Number

WorkCover Claim Number

Clinical Indicators & Relevant History

Examination Requested

☐ **X-Ray**

Please select indications below:

- | | |
|---|--|
| ☐ Skull / Facial Bones | ☐ Pelvis / Hips |
| ☐ Cervical Spine | ☐ Shoulder |
| ☐ Thoracic Spine | ☐ Elbow |
| ☐ Lumbar Spine | ☐ Wrist / Hand |
| ☐ Chest | ☐ Knee |
| ☐ Abdomen | ☐ Ankle / Foot |

☐ Other: _____☐ Left☐ Right☐ **CT Scan**

Please select indications below:

- ☐ Brain
- ☐ Skull / Facial Bones
- ☐ Cervical Spine
- ☐ Chest (HRCT / Lung / PR Protocol)
- ☐ Abdomen / Pelvis

☐ Spine (specify level): _____☐ Extremities (specify): _____☐ CT Angiogram (specify region): _____☐ Other: _____☐ **Contrast Requirements**☐ With Contrast (eGFR) _____☐ Without Contrast ☐ At discretion of radiographer

Medical History

☐ Hypertension☐ Dyslipidaemia☐ Family History☐ Diabetes☐ Smoker

Referring Doctor Details

Doctor Name:

Provider Number:

Address:

Phone:

Fax:

Signature:

Date:

Send Copy To: