SMARTCARE Diagnostics

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Springfield Central
Shop 8,
95 Southern Cross Cct,
Springfield Central
QLD 4300

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
- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar Spine
- ☐ Chest
- ☐ Abdomen
- ☐ Pelvis / Hips
- ☐ Shoulder
- ☐ Elbow
- ☐ Wrist / Hand
- ☐ Knee
- ☐ 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: