



Name

DOB

Address

Sex

Medicare No

Phone

## Diagnostic Request Diagnostic Services Requested

## Referral Details Reason for Referral and Clinical History

## Referring Practitioner's Details (include Practitioner's name and provider number)

Signature

Copy to

## MRI +/- Orbits +/- Skull +/- Chest X-ray

**IMPORTANT:** Indicate whether the following applies to your patient.

- ☐ Y ☐ N History of welding, grinding, sheet metal work
- ☐ Y ☐ N Cardiac pacemaker
- ☐ Y ☐ N Brain aneurysm clip
- ☐ Y ☐ N Cochlear implant
- ☐ Y ☐ N CT Scanning

## CT scanning

- ☐ Y ☐ N If Diabetic, does treatment contain Metformin?

What is current renal function?

Date of renal function?

Most recent eGFR?

## Internal use only

- ☐ Y ☐ N Pregnant
- ☐ Y Patient identification verified
- ☐ Y Procedure and consent verified

Tech name/position:

## Referring Clinical use only

- ☐ Telephone report ( \_\_\_\_\_ )
- ☐ Films with patient

Thank you for referring your patient to Epworth Medical Imaging



## My Appointment

Time

Other

Your doctor has recommended you use Epworth Medical Imaging. You may choose another provider but please discuss this with your doctor first.

[illegible]