

Call for appointment: **07 5531 9300** or **1800 864 723**

Time of appointment:

Date: / /

PATIENT DETAILS

Name

Date of Birth

Telephone

Address

Med. No.

REQUEST FOR

CLINICAL DETAILS

REFERRING DOCTOR DETAILS

PATIENT CATEGORY

RESULTS

- | | | |
|----------------------------------|------------------------------------|--|
| <input type="checkbox"/> Private | <input type="checkbox"/> Vet/AFF | <input type="checkbox"/> Electronic Report |
| <input type="checkbox"/> W/C | <input type="checkbox"/> TAC | <input type="checkbox"/> Files & Report Return With Patient |
| <input type="checkbox"/> Pension | <input type="checkbox"/> Bulk Bill | <input type="checkbox"/> Fax Report No. () |

COPIES TO

DOCTOR SIGNATURE

DATE

PLEASE BRING PREVIOUS FILMS

PATIENT INSTRUCTIONS

Please discuss at time of booking. Contact Uniradiology if you have any queries.
The Following Instructions are for adults. For infants please contact Uniradiology.

◆ ULTRASOUND

Upper Abdomen: Fast for 6 hours prior to examination.
Drink 2-3 glasses of water and hold until examination.

Pelvic: Empty Bladder 2 hours prior to examination. Then drink 4 glasses of water over the next 1/2 hour and hold until examination.

◆ CT SCAN

Brain/Chest/Soft tissue of the neck: Fast 4 hours prior to examination

Abdominal/Pelvis: Fast 4 hours. Arrive 1 hour prior to drink preparation.

X-RAY <input checked="" type="checkbox"/>	U.S <input checked="" type="checkbox"/>	CT <input checked="" type="checkbox"/>	OPG <input checked="" type="checkbox"/>	INTERVENTIONAL <input checked="" type="checkbox"/>	BONE DENSITY <input checked="" type="checkbox"/>	CONE BEAM <input type="checkbox"/>
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