high st XRAY

FOR APPOINTMENTS
T: 5441 9999

149-151 High Street, Bendigo 3550
F: 07 3445 4708 | E: info@highstxray.com.au

APPOINTMENT DETAILS

DATE ...../...../.....

TIME ..... AM/PM

PATIENT NAME	SEX	DATE OF BIRTH	YOUR REFERENCE

PATIENT ADDRESS	POST CODE	TEL (HOME)	TEL (BUS/MOBILE)

MEDICARE CARD NUMBER

TEST REQUIRED

CLINICAL NOTES

EXAMINATION REQUIRED

- ❑ X-RAY
- ❑ ULTRASOUND
- ❑ C.T. SCAN
- ❑ MRI
- ❑ OPG
- ❑ DEXA
- ❑ NUCLEAR MEDICINE
- ❑ INTERVENTIONAL PROCEDURE

Please indicate current renal function.
eGFR: .....
Date: ...../...../.....

REFERRING DOCTOR

NAME PROVIDER NUMBER

ADDRESS

PHONE NUMBER

REFERRING DOCTOR'S SIGNATURE AND DATE

x x

COPIES TO

Please circle if applicable: DVA / WC / TAC

Weight: kg | Height cm

Your doctor has recommended you undergo your diagnostic imaging exam at High St Xray. You may choose another provider but please discuss this with your doctor first.

MRI GENERAL PRACTITIONER MEDICARE BULK BILLED EXAMINATIONS

	TICK	ADULT – 16 years and OVER *Please fax MRI referral - F: 07 3445 4708*
HEAD	❑	Unexplained seizure or unexplained chronic headache with suspected intracranial pathology
CERVICAL SPINE	❑	Suspected cervical radiculopathy
	❑	Suspected cervical spine trauma
KNEE (Under 50yrs old)	❑	Following acute trauma, with inability to extend the knee suggesting the possibility of acute meniscal tear
		CHILD – 15 years and UNDER *Please fax MRI referral - F: 07 3445 4708*
HEAD	❑	Unexplained seizure, headache with suspected significant pathology or paranasal sinus pathology which has not responded to conservative treatment.
SPINE (following X-Ray)	❑	Significant trauma, unexplained neck or back pain with associated neurological signs or suspected significant pathology.
KNEE	❑	Suspected internal joint derangement.
HIP (following X-Ray)	❑	Suspected septic arthritis, slipped capital femoral epiphysis or suspected Perthes Disease.
ELBOW (following X-Ray)	❑	Suspected significant fracture or avulsion injury.
WRIST (following X-Ray)	❑	Suspected scaphoid fracture.

MRI SAFETY – ANSWERS ARE MANDATORY

HAS THE PATIENT NOW OR EVER HAD:	YES / NO	HAS THE PATIENT NOW OR EVER HAD:	YES / NO
An implanted pacemaker, pacing wire, defibrillator or monitor?	❑ / ❑	Any metallic foreign bodies in the eyes?	❑ / ❑
		Any metallic implants?	❑ / ❑
A cerebral aneurysm clip?	❑ / ❑	Is the patient pregnant or breastfeeding?	❑ / ❑
A cochlear or stapes implant?	❑ / ❑	Claustrophobic?	❑ / ❑

(Indications other than those listed above are not currently funded by Medicare for General Practitioner referrals and may incur an out of pocket expense, except where DVA, W/C or TAC funding applies).

PATIENT PREPARATION INSTRUCTIONS

GENERAL X-RAY/DEXA/OPG :

Remove all jewellery and piercings in the area of interest. If possible wear plain clothing without buttons, metal fastenings and decorations.

OBSTETRIC ULTRASOUND :

A full bladder is required. Empty bladder 1.5 hours before appointment, then drink 500ml of water within the next 30 minutes. Do not empty bladder before appointment time. Obstetric ultrasounds greater than 22 weeks do not require a full bladder.

ABDOMINAL ULTRASOUND :

Nothing to eat or drink 6 hours prior to appointment time. You may have sips of water if required. No smoking or chewing gum during fasting period.

PELVIC & RENAL ULTRASOUND :

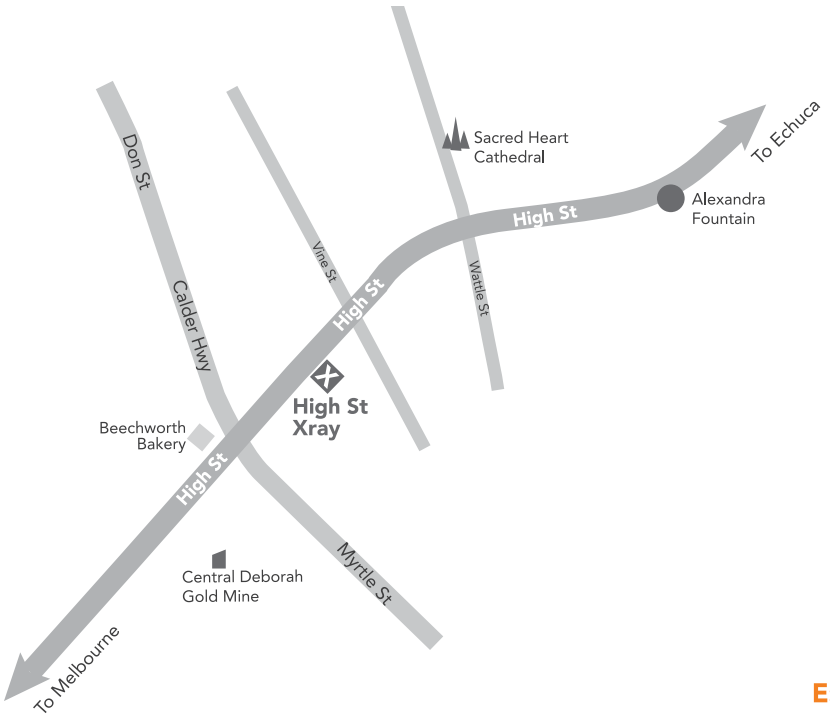
A full bladder is required. Empty bladder 1.5 hours before appointment time, then drink 1 litre of water within the next 30 minutes. Do not empty bladder before appointment.

CT SCAN/NUCLEAR MEDICINE/MRI :

Specific instructions will be given at time of making appointment.

For more information regarding your procedure please refer to highstxray.com.au

PLEASE BRING THIS REQUEST FORM AND YOUR MEDICARE CARD TO YOUR APPOINTMENT



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