ROYAL HOBART HOSPITAL MEDICAL IMAGING OUTSIDE REFERRAL

DATE

COMPENSABLE DETAILS:
☐ WCC ☐ TP ☐ DVA ☐ PRV

Patient Name: URN:
Address: DOB:

EXAMINATION REQUIRED

REPORT REQUIRED BY (DATE): .....

REASON:
❑ EXCLUSION
❑ INVESTIGATION
❑ MONITORING

PLEASE AFFIX PATIENT DETAILS LABEL

Ph (H)
(W)

RELEVANT CLINICAL INFORMATION:

DEPARTMENT USE

PATIENT STATES:
❑ IS
❑ MAY BE
❑ IS NOT
PREGNANT

RADIOGRAPHER

SERIES | FILMS

CONTRAST ALLERGIES: ❑ YES ❑ NO. METFORMIN: ❑ YES ❑ NO. CREATININE ..... DATE: .....

SIGNATURE OF REFERRING DOCTOR | NAME OF REFERRING DOCTOR (PLEASE PRINT) | PROVIDER No. | REFERRING DOCTOR ADDRESS:

TELEPHONE No.;

IT IS A LEGAL REQUIREMENT THAT THE ABOVE DETAILS ARE COMPLETED IN FULL BY A MEDICAL PRACTITIONER

THS-S 168207 06/16 P&P 49635 JUN16 M8

MEDICAL IMAGING CONTACT INFORMATION

	Phone	Fax
General X-ray	6166 8237	03 6173 0425
Ultrasound / CT	6166 8343	03 6173 0425
MRI	6166 8816	03 6173 0425
Nuclear Medicine	6166 8534	6222 8864