Qscan
RADIOLOGY CLINICS

Phone: 1300 177 226
Email: techsupport@qscan.com.au

IMAGE TRANSFER REQUEST

I certify that the studies requested below are required for the ongoing clinical management of the patient indicated and that disclosure of this information is not contrary to their wishes.

Requested by

Name (PRINT):

Phone:

Signature:

Date: Date Required:

For Review By

Name (PRINT):

Patient Details

Name (PRINT):

Date of Birth: Qscan Patient ID (if available):

From:	To:	
☐ Qscan techsupport@qscan.com.au	☐ Mater Public Hospital	☐ Toowoomba Hospital
	☐ Princess Alexandra Hospital	☐ Gold Coast University Hospital
	☐ Redcliffe Hospital	☐ Redlands Hospital
	☐ Logan Hospital	☐ Prince Charles Hospital
	☐ RBWH	☐ Other QH Enterprise PACS location

Exam Details

Procedure:	Date:

Please email this request to techsupport@qscan.com.au and allow 24 hours for completion.
NB. Incomplete or illegible forms will not be accepted.

Office Use Only:

Completed By: .... Date: ....