

# PODIATRY REFERRAL



## PATIENT DETAILS

Patient name:

Birth date:

Address:

Phone:

Mobile:

WorkCover claim number:

## X-RAY EXAMINATION REQUESTED

Weight bearing (base of gait)

Non weight bearing

Left

Right

Bilateral

### FOOT

A.P.

Lateral

Lateral oblique

Medial oblique

### TARSUS

Calcaneal axial

Harris & Beath

Broden

### SESAMOIDS

Axial sesamoids

### SUBTALAR & ANKLE

A.P.

Lateral

Superoinferior oblique

Ultrasound

Region \_\_\_\_\_

Body composition DXA scan

## CLINICAL DETAILS

Pregnant  No  Yes  Unsure

## REFERRING PRACTITIONER

Name:

Address:

Phone:

Fax:

Provider number:

Send copy to:

Signature:

Date:

See reverse side of this referral for contact details to organise your appointment or book online at [qscan.com.au/bookings](https://qscan.com.au/bookings).

Thank you for referring your patient to Qscan Radiology Clinics.

### MORE REFERRAL PADS

A4 (computerised)

A5 (manual)

# YOUR NEXT APPOINTMENT

Date: \_\_\_\_\_

Time: \_\_\_\_\_

Preparation: \_\_\_\_\_

Please bring this referral to your appointment



## OUR LOCATION



### Rockingham

2 Civic Boulevard  
Rockingham WA 6168

- X-ray
- Ultrasound
- CT
- PET-CT
- BMD
- DXA body composition

p: (08) 9500 8950  
f: (08) 6444 7480  
e: petrockingham@qscan.com.au



### Midland

81 Yelverton Drive  
Midland WA 6056

- X-ray
- Ultrasound
- CT
- PET-CT

p: (08) 6155 5500  
f: (08) 6266 3719  
e: midland@qscan.com.au

All images are digitally archived for ten years and can be accessed by your doctor online anytime.

Your Doctor has recommended you attend Qscan Radiology Clinics. You may choose another provider but please discuss this with your Doctor first.