ORTHOPEDIC REFERRAL

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Qscan RADIOLOGY CLINICS

PATIENT DETAILS

Patient name

Birth date

Contact details

Medicare number

WorkCover claim number

EXAMINATION REQUESTED

☐ **Right** ☐ **Left** ☐ **Bilateral**

X-RAY

SHOULDER ☐ A/P ☐ Lateral ☐ Axillary ☐ Garth ☐ Int Rotation ☐ Ext Rotation ☐ S/C Joint ☐ A/C Joint

WRIST ☐ A/P ☐ Lateral ☐ Oblique ☐ Scaphoid ☐ Clenched Fist

HIP ☐ AP pelvis ☐ AP & Lateral Hip ☐ Frogleg Lateral ☐ Include proximal 1/3 of femur ☐ Calibrated 25mm

KNEE ☐ AP & Lateral ☐ Intercondylar ☐ Skyline (Patella) ☐ Weight Bearing

LONG LEG ☐ AP View inc. Hip, Knee & Ankle

FOOT/ANKLE ☐ AP & Lateral ☐ Mortise ☐ Med oblique ☐ Lateral Oblique ☐ Calcaneum ☐ Weight Bearing

OTHER ☐ _____

CT ☐ CT at X-ray doses * ☐ *(Mater, Meadowbrook, Redcliffe, Windsor only)*

MRI ☐ **ARTHROGRAM** ☐

US ☐ ☐ Duplex ☐ Dynamic

EOS ☐ ☐ Pelvis/Legs ☐ Spine/Pelvis ☐ Full Body

INTERVENTIONAL ☐ Inject with _____ under Image Guidance

NUCLEAR MEDICINE ☐

CLINICAL DETAILS

REFERRING PRACTITIONER

Name

Phone Fax

Address

Provider number

Send copy to

Signature Date

IMAGES ☐ Online ☐ CD ☐ Print Films ☐ Courier / Deliver

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

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