General Referral

Please complete and email to: **webbookings@qscan.com.au**
OR upload securely to our website: **qscan.com.au/bookings**

Qscan RADIOLOGY CLINICS

Patient name:

Birth date:

Address:

Phone: Mobile:

WorkCover claim number:

EXAMINATION REQUESTED

- ☐ X-ray
- ☐ X-ray weight bearing
- ☐ Ultrasound
- ☐ CT scan
- ☐ CT angiogram
- ☐ CT coronary angiogram
- ☐ Mammography
- ☐ Interventional procedure
- ☐ Nuclear medicine SPECT/CT
- ☐ PET with diagnostic CT
- ☐ PET with non-diagnostic CT
- ☐ Bone mineral densitometry
- ☐ Body composition DXA scan
- ☐ MRI scan
- ☐ EOS imaging
- ☐ OPG
- ☐ Cone beam
- ☐ Echocardiogram
- ☐ Other

CLINICAL DETAILS

Contrast allergy ☐ No ☐ Yes

Renal impairment ☐ No ☐ Yes eGFR _____

Pregnant ☐ No ☐ Yes ☐ Unsure ☐ Not Applicable

REFERRING PRACTITIONER

Name:

Address:

Phone: Fax:

Provider number:

Signature: Date:

Send copy to:

THANK YOU FOR CHOOSING QSCAN RADIOLOGY CLINICS

5549S-14