

GREATER SOUTHERN IMAGING SERVICE

PATIENT DETAILS

IDENTIFIER:

SURNAME:

GIVEN NAME(S): D.O.B. .../.../...

ADDRESS:

PHONE: (.....)..... POSTCODE:

FINANCIAL STATUS

O.P. E.D.

I.P. - WARD:

PRIVATE PUBLIC

DVA MVA WC

OTHER

MEDICARE NO:

IMAGING MODALITY

XRAY

CT SCAN

ULTRASOUND

VASCULAR ULTRASOUND

BONE DENSITOMETRY

DSA

BREAST IMAGING

SCREENING

INTERVENTIONAL RADIOLOGY MRI

NUCLEAR MEDICINE

EXAMINATION(S) REQUIRED

CLINICAL HISTORY / PROVISIONAL DIAGNOSIS

MOBILITY STATUS / MEDICAL REQUIREMENTS

WALKING

WHEEL CHAIR

BED

A&E BED

OXYGEN

I.V.

NURSE ESCORT REQUIRED

ALLERGIES

SPECIAL INSTRUCTIONS

FILMS WITH PATIENT URGENT

FAX REPORT E-MAIL REPORT

OTHER:

COPIES TO:

REFERRING CLINICIAN

REFERRED BY:

ADDRESS:

PROVIDER NO:

SIGNATURE:

DATE: .../.../... PHONE: (.....).....

MEDICAL RADIATION SCIENTIST NOTES

OFFICE USE ONLY

RADIOGRAPHER:

NUMBER OF FILMS:

CORRECT PATIENT

CORRECT SIDE

CORRECT SITE

CORRECT MARKING

CORRECT PROCEDURE

CONSENT