BAYSIDE RADIOLOGY

# DENTAL IMAGING REQUEST

## PATIENT DETAILS

**Name*** **DOB***

**Address***

**Contact Number*** ☐ Workers Comp

**Medicare Number** ☐ Third Party

## EXAMINATION REQUESTED

- ☐ OPG
- ☐ Lat Ceph
- ☐ TMJ
- ☐ Sinuses
- ☐ Bone Age
- ☐ Other

## AREA TO BE EXAMINED

Upper Jaw

18 17 16 15 14 13 12 11 21 22 23 24 25 26 27 28

Lower Jaw

48 47 46 45 44 43 42 41 31 32 33 34 35 36 37 38

## AREA TO BE EXAMINED & CLINICAL NOTES

☐ Allergies ☐ Urgent

For IV contrast exams, recent creatinine level / eGFR:

## REFERRER DETAILS

**Name*** **Speciality***

**Address*** **Provider Number***

**Contact Number*** **Fax Number:**

*Must be completed

**Signature*** **Date***

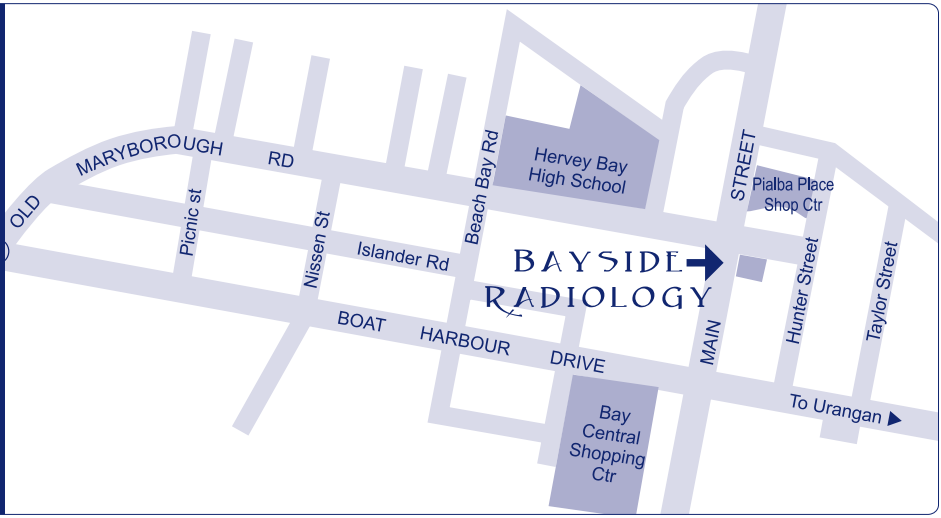
*All reports and images are available electronically. Please tick below for your additional requests.* ☐ Referral Pads Required

**REPORTS** ☐ Urgent Results ☐ Fax ☐ Download ☐ Phone ☐ Film ☐ Copy reports to:

BAYSIDE RADIOLOGY

# DENTAL IMAGING REQUEST

## WHERE TO FIND US




## CONTACT DETAILS

46 Main Street
PO Box 1916
Hervey Bay, QLD 4655

(07) 4197 6600
(07) 4197 6622

bookings@bayrad.com.au

**MRI BOOKINGS:**
mri@bayrad.com.au

Monday to Friday
8.00am - 5.00pm
Closed weekends and
public holidays

ABN 63 657 027 515

## OTHER SERVICES

- **General X-Ray**
- **OPG / Dental**
- **MRI**
- **CT (low dose)**
- **Ultrasound**
  - General
  - Obstetrics / Gynaecology
  - Musculoskeletal
  - Vascular
  - Doppler
- **Interventional Procedures**
- **Echocardiography**
- **FNA & Core Biopsy**
- **3D Mammography**
- **Bone Mineral Density**

*Your doctor has recommended you use Bayside Radiology. You may choose another provider but please discuss this with your doctor first.*