BOLSOVER RADIOLOGY

CHIROPRACTIC REQUEST

PATIENT DETAILS

Name* **DOB***

Address*

Contact Number* ☐ Workers Comp

Medicare Number ☐ Third Party

EXAMINATION REQUESTED

☐ Erect ☐ Supine

☐ Cervical Spine: **A.P**
☐ Cervical Spine: **A.P Open Mouth**
☐ Cervical Spine: **Oblique**
☐ Cervical Spine: **Lateral (Neutral)**
☐ Cervical Spine: **Lateral (Flex/Ext)**
☐ Thoracic : **A.P**
☐ Thoracic : **Lateral**

☐ Lumbar Spine: **A.P (incl. Pelvis)**
☐ Lumbar Spine: **A.P**
☐ Lumbar Spine: **Lateral (Neutral)**
☐ Lumbar Spine: **Lateral (Flex/Ext)**
☐ Lumbar Spine: **Oblique**
☐ Pelvis: **Pelvis**

Non Referred / No Rebate Items

☐ **X-Ray (Other):**

☐ **Ultrasound:**

☐ **Other:**

AREA TO BE EXAMINED & CLINICAL NOTES

☐ Allergies ☐ Urgent Pregnant: ☐ YES ☐ NO

For IV contrast exams, recent creatinine level / eGFR:

REFERRER DETAILS

Name* **Speciality***

Address* **Provider Number***

Contact Number* **Fax Number:**

*Must be completed

Signature* **Date***

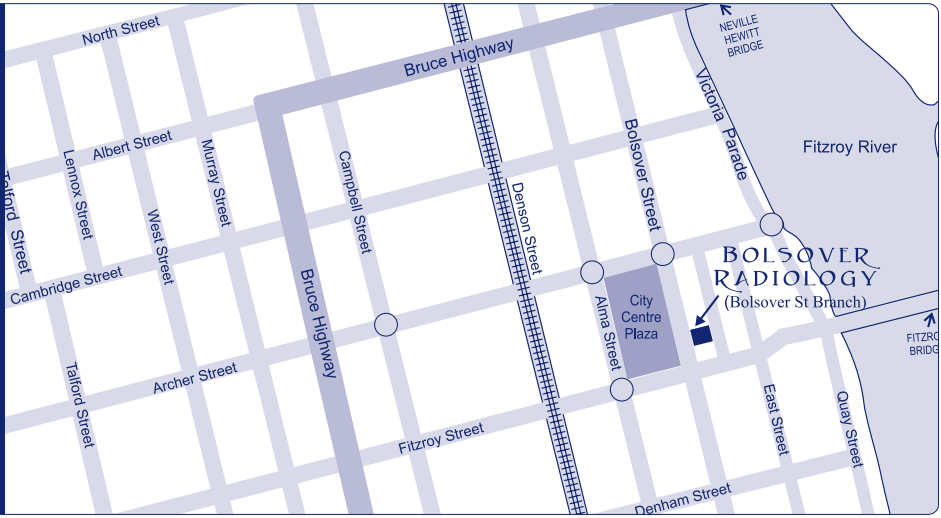
All reports and images are available electronically. Please tick below for your additional requests. ☐ Referral Pads Required

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

BOLSOVER RADIOLOGY

CHIROPRACTIC REQUEST

WHERE TO FIND US



CONTACT DETAILS

129 Bolsover Street
PO Box 920
Rockhampton, QLD 4700

(07) 4930 7500

(07) 4930 7522

bookings@bolrad.com.au

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

ABN 18 658 115 532

OTHER SERVICES

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

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