



PATIENT DETAILS

Name* _____ DOB* _____

Address* _____

Contact Number* _____ Workers Comp

Medicare Number _____ Third Party

EXAMINATION REQUESTED

Erect Supine

Cervical Spine: A.P. Lumbar Spine: A.P (incl. Pelvis)

Cervical Spine: A.P Open Mouth Lumbar Spine: A.P

Cervical Spine: Oblique Lumbar Spine: Lateral (Neutral)

Cervical Spine: Lateral (Neutral) Lumbar Spine: Lateral (Flex/Ext)

Cervical Spine: Lateral (Flex/Ext) Lumbar Spine: Lateral (Flex/Ext)

Thoracic : A.P Lumbar Spine: Oblique

Thoracic : Lateral 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* _____

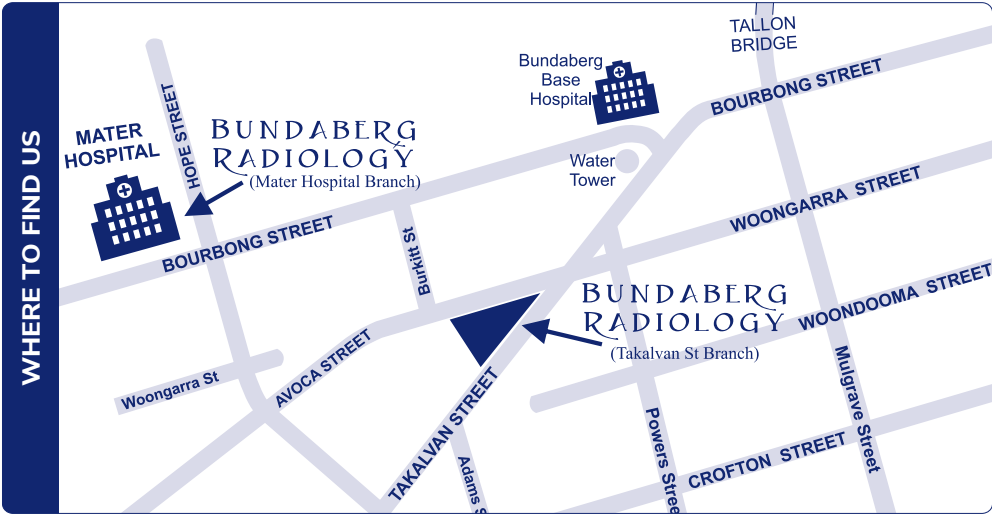
Contact Number* _____ Fax Number: _____

**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:



WHERE TO FIND US

CONTACT DETAILS

- 3A Takalvan St, Bundaberg, QLD 4670
- Mater Hospital, Cnr Bourbong & Hope St, Bundaberg, QLD 4670
- (07) 4150 0200
- (07) 4150 0222
- bookings@bundryrad.com.au
- MRI BOOKINGS:**
mribookings@bundryrad.com.au
- Monday to Friday
8.30am - 5.00pm
Closed weekends and public holidays
ABN 23 657 027 346

OTHER SERVICES

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

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



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