

IMAGING/CONSULTATION REQUEST

I confirm that prior to this examination the following processes were completed: Patient ID & Procedure Matching Process Informed Consent Obtained Staff Initial FOR ALL EXAMINATIONS USING RADIATION

FOR OFFICE USE ONLY
PRE-EXAMINATION CHECK

 PREGNANT?
 Yes
 No

 If yes, I confirm that Radiologist consent was obtained with approval to proceed
 Yes
 No

Contrast Allergies	Yes 🗌 No 🗌
Renal Disease	Yes 🗌 No 🗌
Diabetes Metformin Treatment	Yes 🗌 No 🗌
Blood Thinning Medication	Yes No
Pacemaker	Yes No

For IV contrast exams, recent creatinine level / eGFR:

REFERRER DETAILS

Signature* Date* All reports and images are available electronically. Please tick below for your additional requests. Referrals Forms Required REPORTS Urgent Results Fax Download Phone Film Copy reports to:

Disclaimer: Where deemed necessary for patient management please accept this request as a referral for consultation to investigate the patient's condition and history and form an opinion on the specific treatment required for the management of the condition or problem.



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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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