Radiology Referral

ENVISION
MEDICAL IMAGING

PATIENT DETAILS

Patient name:

Birth date:

Contact details:

Medicare number:

WorkCover claim number:

EXAMINATION REQUESTED

- ☐ CT Scan
  - ☐ CT Chest
    - ☐ Low dose CT (CXR replacement)
    - ☐ HRCT chest
  - ☐ CTCA
  - ☐ Cone Beam
  - ☐ OPG
- ☐ MRI
  - ☐ Ultrasound
  - ☐ X-ray
- ☐ Nuclear medicine
  - ☐ PET-CT
  - ☐ Interventional procedure
  - ☐ Other _____

CLINICAL DETAILS

Contrast allergy ☐ No ☐ Yes

Renal impairment ☐ No ☐ Yes eGFR _____

Pregnant ☐ No ☐ Yes ☐ Unsure ☐ Not Applicable

REFERRED BY

Contact details:

Provider number:

Send copy to:

Signature: Date:

0325