Alpenglow AUSTRALIA

RADIOLOGY REFERRAL

PATIENT DETAILS

Patient name: DOB: Phone:

Address:

Medicare: Pension card ☐ Healthcard card ☐

EXAMINATION

Iodine Contrast Studies *(tick if any of the following apply)*

☐ Over 70 ☐ Diabetic ☐ Renal Impairment ☐ on Metformin

MEDICAL IMAGING FINAL CHECK

	YES
• Patient identification verified	☐
• Procedure and consent verified	☐
• Correct side and site verified	☐
• Correct patient data and side markers	Staff initial

Radiographer / Sonographer

Signature _____

CLINICAL NOTES

Pregnant: Yes ☐ No ☐

Patient Sign: _____

Infectious: Yes ☐ No ☐

eGFR _____ **Date** _____

Please provide eGFR from within past 3 months

Nuchal Ultrasound

Risk of abnormality or increased risk factors:

MRP/Operator Comments:

REFERRING PRACTITIONER

Name: Provider number:

Address:

Phone:

Signature: Date:

Send copy to:

Your doctor has recommended that you attend an Alpenglow Australia Clinic.
You may choose another provider but please discuss this with your doctor first.

alpenglow.com.au

26595