



APPOINTMENT DETAILS

DATE:/...../.....

TIME: AM/PM

PATIENT NAME	SEX	DATE OF BIRTH	APPROVED BY
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PATIENT ADDRESS	POSTCODE	TEL (HOME)	TEL (BUS/MOBILE)
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MEDICARE CARD NUMBER

TEST REQUIRED

CLINICAL NOTES

EXAMINATION REQUIRED

X-RAY

ULTRASOUND

C.T. SCAN

MRI

NUCLEAR MEDICINE

Please indicate current renal function.

eGFR:

MRI INFORMATION

IMPORTANT
Indicate whether the following applies to your patient

History of welding, grinding, sheet metal work? Yes No

An implanted pacemaker/pacing wire or defibrillator? Yes No

Brain aneurysm clip? Yes No

Cochlear or staples implant? Yes No

Claustrophobic? Yes No

Is the patient pregnant or breastfeeding? Yes No

REFERRING DOCTOR

NAME PROVIDER NUMBER

ADDRESS

PHONE NUMBER

REFERRING DOCTOR'S SIGNATURE AND DATE

X X

COPIES TO



1017 Howitt Street, Wendouree 3355

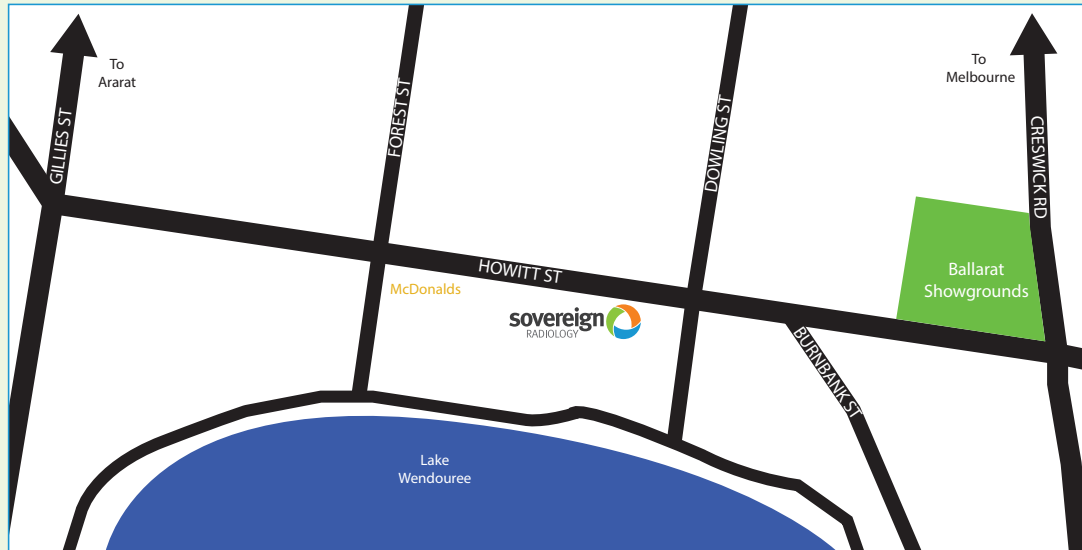
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- XRAY
- CT
- ULTRASOUND
- NUCLEAR MEDICINE
- MRI
- INTERVENTIONAL PROCEDURES



PATIENT PREPARATION INSTRUCTIONS

GENERAL X-RAY: None required.

OBSTETRIC ULTRASOUND (PREGNANCY): A full bladder is required. Empty bladder 1.5 hours before appointment time, then drink 500 ml of water within the next 30 minutes. Do not empty bladder before appointment time. Obstetric ultrasounds later than 22 weeks do not require a full bladder.

ABDOMINAL ULTRASOUND: Nothing to eat or drink 6 hours prior to appointment time. You may have sips of water if required. No smoking or chewing gum during fasting period.

PELVIC & RENAL ULTRASOUND: A full bladder is required. Empty bladder 1.5 hours before appointment time, then drink 1 litre of water within the next 30 minutes. Do not empty bladder before appointment time.

CT SCAN/NUCLEAR MEDICINE/MRI: Specific instructions will be given at the time of making appointment.

****PLEASE BRING THIS REQUEST FORM, MEDICARE CARD & ANY RELEVANT PREVIOUS FILMS FOR COMPARISON****