ROYAL HOBART HOSPITAL — MEDICAL IMAGING — OUTSIDE REFERRAL

DATE

COMPENSABLE DETAILS:
☐ WCC ☐ TP ☐ DVA ☐ PRV

Patient Name: URN:
Address: DOB:

EXAMINATION REQUIRED

REPORT REQUIRED BY (DATE):.....

REASON:
- ❑ EXCLUSION
- ❑ INVESTIGATION
- ❑ MONITORING

PLEASE AFFIX PATIENT DETAILS LABEL

Ph (H)
(W)

RELEVANT CLINICAL INFORMATION:

DEPARTMENT USE

PATIENT STATES:
- ❑ IS
- ❑ MAY BE
- ❑ IS NOT

PREGNANT

RADIOGRAPHER

SERIES | FILMS

CONTRAST ALLERGIES: ❑ YES ❑ NO. METFORMIN: ❑ YES ❑ NO. CREATININE.....DATE:.....

SIGNATURE OF REFERRING DOCTOR	NAME OF REFERRING DOCTOR (PLEASE PRINT)	PROVIDER No.	REFERRING DOCTOR ADDRESS: TELEPHONE No.;

IT IS A LEGAL REQUIREMENT THAT THE ABOVE DETAILS ARE COMPLETED IN FULL BY A MEDICAL PRACTITIONER