

ALLIED HEALTH IMAGING REQUEST



PATIENT DETAILS

NAME*DOB*

Address*

Contact Number*Workers Comp

Medicare NumberThird Party

EXAMINATION REQUESTED

FULL MEDICARE REBATE
Requested by Podiatrist

FULL MEDICARE REBATE
Requested by Osteo & Physio

REDUCED MEDICARE REBATE
Requested by all Allied Health

AREA TO BE EXAMINED
& CLINICAL NOTES

☐ X-Ray Foot L / R

☐ X-Ray Ankle L / R

☐ X-Ray Knee L / R

☐ X-Ray Lower Leg L / R

☐ US Mid/Forefoot L / R

☐ US Ankle/Hindfoot L / R

☐ US of Mass

☐ X-Ray Cervical Spine

☐ X-Ray Thoracic Spine

☐ X-Ray Lumbar Spine

☐ X-Ray Sacrococcygeal

☐ X-Ray Hip

☐ X-Ray Pelvis

☐ X-Ray Region (Other):

☐ Ultrasound Region:

☐ MRI (No Rebate)

☐ Other Examination:

☐ Allergies

☐ Urgent Pregnant:☐ YES ☐ NO

For IV contrast exams, recent creatinine level / eGFR:

REFERRER DETAILS

NAME*Speciality*

Address*Provider Number*

Contact Number*Fax Number:

*Must be completed

Signature*Date*

All reports and images are available electronically. Please tick below for your additional requests. ☐ Referral Pads 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.

- ☐ **X-RAY/OPG:** No appointment or preparation required.
- ☐ **CT:** You will receive instructions before your appointment.
- ☐ **ULTRASOUND ABDOMEN:** Fast for 8 hours, nothing to eat, drink, chew or smoke prior to appointment. Small sips of water and medication allowed.
- ☐ **ULTRASOUND PELVIS/KUB & OBSTETRIC:** Must present with full bladder, we suggest drinking 1L of water to be completed 1 hour prior to appointment time. Further instructions to be provided.
- ☐ **MAMMOGRAPHY:** Do not wear perfume, deodorant or powder before your exam. A two-piece outfit is preferred, as you will need to remove everything from the waist up.
- ☐ **MRI:** As advised by booking clerk.

Appointment Date: _____ **Appointment Time:** _____

Preparation Notes: _____

Scan to
request an
appointment
online



	X-Ray	Ultrasound	Bone Density Study (BMD)	Mammography	Dental/OPG	CT	MRI	CT Calcium Scoring & Cardiac Angiography	Interventional Radiology & Pain Management	Euflexxa Injections
Shire Medical Imaging	■	■	■	■	■	■	■	■	■	■
Bankstown Lidcombe Medical Imaging	■	■	■	■	■	■	■	■	■	■
Oran Park Radiology	■	■	■	■	■	■	■	■	■	■

Your doctor has recommended you use **Shire Medical Imaging**.
You may choose another provider but please discuss this with your doctor first.

SHIRE MEDICAL IMAGING

Level 1, 86 Kiara Rd Miranda NSW 2228

Tel: 02 9525 7770

Fax: 02 9525 3797

Email: info@shiremedicalimaging.com.au

www.shiremedicalimaging.com.au

SHIRE WOMEN'S IMAGING

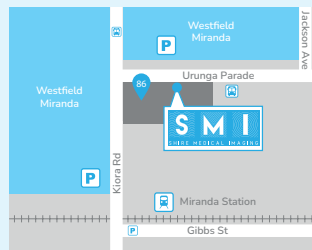
Upper Ground Floor,
86 Kiara Rd Miranda NSW 2228

Tel: 02 9531 1133

Fax: 02 9526 7229

Email: info@shirewomensimaging.com.au

www.shirewomensimaging.com.au



Free 3 hour parking at Westfield Miranda

BANKSTOWN LIDCOMBE MEDICAL IMAGING

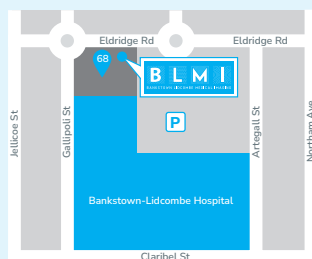
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