BROKEN HILL RADIOLOGY

Your doctor has recommended that you use Broken Hill Radiology. Any change to this recommendation should be discussed with your doctor first.

Patient Details

NAME: DOB: AGE:
MEDICARE NUMBER:
ADDRESS:

PHONE:

Requested Test

Urgent ☐

Insert specific scan details here.

Clinical Notes / Reason for referral

Insert clinical history, symptoms, and indications here.

ALLERGIES:
RENAL FUNCTION (IF CONTRAST REQUIRED):

Requesting Practitioner's Details

REFERRING DOCTOR: PROVIDER NUMBER:
PRACTICE:

PHONE: FAX:

SIGNATURE: _____ DATE:

Report Copy to

FULL NAME: PROVIDER NUMBER:
PRACTICE:
PHONE: FAX:

Privacy Note: The information provided will be used by Broken Hill Radiology to assess any Medicare benefit payable for the services rendered and to facilitate proper administration of government health programs and may be used to update enrolment records. Its collection is authorised by provisions of the Health Insurance Act 1973. The information may also be used by Broken Hill Radiology to facilitate proper administration, to update clinic patient records and may be shared with your treating healthcare providers. The information may be disclosed to the Department of Health and Ageing or to a person in the medical practice associated with this claim and / or service, or as authorised by law.

BROKEN HILL RADIOLOGY

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