Imaging Request

ASPIRE RADIOLOGY
YOUR HEALTH OUR FOCUS

Patient Details		
Name:		DOB:
Address:		
		Postcode:
Telephone:		Mobile:
Medicare No:	expiry date: /	Concession card:

Exam Requested ▢ **Urgent appointment**

▢ X-Ray	▢ CT	▢ CT Angiography	▢ Ultrasound
▢ OPG & Lat Ceph	▢ Cone Beam CT	▢ Interventional Procedure	▢ DEXA

Imaging Examination:

Reason for Referral & Clinical Question:

▢ Allergies (list): ▢ Metformin ▢ positive Beta HCG

If Renal Function Impaired, recent Creatinine level / eGFR:

All reports and images are available electronically. Please tick for any additional requirements:
▢ Phone ▢ Urgent results

Referrer Details (MUST be completed)

Referrer Name:

Provider Number:

Phone:

Copy reports to:

Signature: Date: / /

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Shop 3049, Westfield Hornsby, NSW 2077
Tel: 02 9070 1172 Fax: 02 8088 7905
Email: info@aspireradiology.com.au