ASPIRE RADIOLOGY

YOUR HEALTH OUR FOCUS

Imaging Request - Hornsby ☐ Dural ☐

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	**Copy reports to:**
Referrer Name:	
Provider Number:	
Phone:	

Signature: Date: / /

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