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- URGENT (SAME DAY)
- NON-URGENT (NEXT DAY)

Please fill the X-Ray Request Form, obtain the consent from Next-Of-Kin of the patient, and send us via email or fax to schedule a booking. Please contact us for further information.

Radiographer Info

Name: _____
Patient Details Entered
Image Sent for reporting
Initials: _____ Date: _____

X-RAY REQUEST FORM

PATIENT DETAILS

SURNAME: _____
FIRST NAME: _____
DOB: ___/___/_____ GENDER: M F
ADDRESS (ACF): _____
MEDICARE NO: _____ IRN: ___ EXP: ___/___/_____
DVA NO: _____
PENSION NO: _____

KNOWN ALLERGIES:

EXAMINATION REQUESTED

CLINICAL INFORMATION

REFERRER DETAILS

SURNAME: _____
FIRST NAME: _____
PROVIDER NO: _____
ADDRESS: _____
SIGNATURE: _____ DATE: ___/___/_____
Copies To: _____