

Patient Details (Name, Address,
DOB, Medicare number)

Date:

Diagnostic Request

Reason for referral and clinical history

Follow-up appointment with Referring Doctor:

Referring Practitioner's Details

Practitioner's Name:

Address:

Signature: _____

Copy to: _____

Thank you for referring your patient to Queensland X-Ray.



**For bookings
scan here**

or call 1300 781 926

Phone lines open from:

7am - 8pm Monday - Friday

7am - 4pm Saturday

Internal Use Only

	Yes	No
Pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Front Office Check	<input type="checkbox"/>	<input type="checkbox"/>
Patient Identification verified	<input type="checkbox"/>	<input type="checkbox"/>
Procedure and consent verified	<input type="checkbox"/>	<input type="checkbox"/>
Correct side and site verified	<input type="checkbox"/>	<input type="checkbox"/>
Film preference verified	<input type="checkbox"/>	<input type="checkbox"/>
Correct patient data and side markers		
Tech initials:	_____	
Team leader signature:	_____	

