

### CHIROPRACTIC + OSTEOPATHIC IMAGING REQUEST

#### PATIENT DETAILS

Name: ..... D.O.B: ..... / ..... / .....

Address: ..... Telephone: .....

Suburb: ..... Postcode: ..... Medicare No: .....

#### EXAMINATION REQUIRED

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Cervical Spine  | <input type="checkbox"/> AP Cervical                          | <input type="checkbox"/> AP - Alanto - Axial (APOM) | <input type="checkbox"/> Lat Neutral               |
|  | <input type="checkbox"/> Lateral - Flex/Ext                   | <input type="checkbox"/> Oblique View               | <input type="checkbox"/> Lat Cervico - Thoracic Jn |
| <input type="checkbox"/> Thoracic        | <input type="checkbox"/> AP Thoracic                          | <input type="checkbox"/> Lat Thoracic               |  |
| <input type="checkbox"/> Lumbar / Pelvic | <input type="checkbox"/> AP Lumbar                            | <input type="checkbox"/> Lat Neutral                | <input type="checkbox"/> Lat - Flex / Ext          |
|  | <input type="checkbox"/> Lat L5/S1                            | <input type="checkbox"/> Oblique Views              | <input type="checkbox"/> Sacro - Iliac Joints      |
|  | <input type="checkbox"/> AP Lumbo - Pelvic                    | <input type="checkbox"/> AP Pelvis                  |  |
| <input type="checkbox"/> Full Spine      | <input type="checkbox"/> AP Cerv - Thor - Lumbar              |   |  |
| <input type="checkbox"/> MRI             | <input type="checkbox"/> AP Cerv - Thor - Lumbar & Pelvis 36" |   |  |
| <input type="checkbox"/> Other           |   |   |  |

#### CLINICAL NOTES

Image delivery:  ONLINE  FILMS  CD

#### REFERRER DETAILS

Referrer Name: ..... Provider Number: .....

Address: ..... Telephone: .....

Postcode: .....

Signature: ..... Date: ..... / ..... / .....

COPY TO: .....

#### OFFICE USE ONLY

Verbal Consent Given

Procedure: .....

Justified and approved by: .....

Date: ..... / ..... / .....

Time out check...

1. Correct Patient
2. Correct exam
3. Correct side
4. Pregnant  YES  NO

**PLEASE TURN OVER FOR PATIENT PREPARATION INSTRUCTIONS AND CLINIC LOCATION**

Your Doctor has recommended you see Sovereign Radiology. You may choose another provider but please discuss this with your doctor first

1017 Howitt Street, Wendouree 3355

T: 4333 0333

F: 5303 0218

W: [www.sovereignradiology.com.au](http://www.sovereignradiology.com.au)

E: [info@sovereignradiology.com.au](mailto:info@sovereignradiology.com.au)



- X-RAY
- OPG
- CT
- ULTRASOUND
- NUCLEAR MEDICINE
- MRI
- INTERVENTIONAL PROCEDURES
- PAIN MANAGEMENT

### PATIENT PREPARATION INSTRUCTIONS

**GENERAL X-RAY:** No preparation or appointment required.

**MRI:** Appointment required.

**\*\*PLEASE BRING THIS REQUEST FORM AND MEDICARE CARD WITH YOU\*\***

