

*"A proudly Ballarat owned and operated clinic"*

## CHIROPRACTIC + OSTEOPATHIC IMAGING REQUEST

### PATIENT DETAILS

Name: ..... D.O.B: ..... / ..... / .....  
 Address: ..... Telephone: .....  
 Suburb: ..... Postcode: ..... Medicare No: .....

### EXAMINATION REQUIRED

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> <b>Cervical Spine</b>  | <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"/> <b>Thoracic</b>        | <input type="checkbox"/> AP Thoracic                      | <input type="checkbox"/> Lat Thoracic               |  |
| <input type="checkbox"/> <b>Lumbar / Pelvic</b> | <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"/> <b>Full Spine</b>      | <input type="checkbox"/> AP Cerv - Thor - Lumbar          |   |  |
| <input type="checkbox"/> <b>MRI</b>             | <input type="checkbox"/> AP Cerv - Thor - Lumbar & Pelvis |   |  |
| <input type="checkbox"/> <b>Other</b>           |   |   |  |



**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

### Wendouree Clinic

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)

### Sebastopol Clinic

Ground Floor 49-51 Albert Street, Sebastopol 3356

T: 4333 0355

F: 9957 0366

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

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

### PATIENT PREPARATION INSTRUCTIONS

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

**MRI:** Appointment required.

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

LOCATION	X-RAY	OPG	DEXA	US	ECHO	CT	MRI	IR
Wendouree Clinic	✓	✓	✗	✓	✓	✓	✓	✓
Sebastopol Clinic	✓	✓	✓	✓	✗	✓	✗	✓

