

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

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- 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****

