sovereign RADIOLOGY

FOR APPOINTMENTS
PHONE 4333 0333

OPENING HOURS:
Mon to Fri: 8:30am to 5:30pm

DENTAL IMAGING REQUEST

PATIENT DETAILS

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

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

Suburb: .... P/code: .... Medicare No: ....

DENTAL

- ☐ OPG
- ☐ Lateral Cephalogram
- ☐ Frontal (PA) Cephalogram
- ☐ Bone Age
- ☐ TMJ's
- ☐ Lat C Spine

CT Dentascan

- ☐ Maxilla
- ☐ Mandible
- ☐ Both

R	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8	L
	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8	

CLINICAL NOTES

- ☐ Implant Placement
- ☐ Trauma
- ☐ Impacted Teeth
- ☐ Other:
- ☐ Mandibular Canal Marking
- ☐ Sinuses
- ☐ Orthodontic Planning
- ☐ Maxillofacial Surgery
- ☐ TMJ
- ☐ Soft Tissue / Airway

Image Delivery:
☐ On-line ☐ Films ☐ CD

REFERRER DETAILS

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

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

Postcode: ....

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

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

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1017 Howitt Street, Wendouree 3355

T: 4333 0333

F: 5303 0218

W: www.sovereignradiology.com.au

E: info@sovereignradiology.com.au

- X-RAY
- OPG
- LOW DOSE CT SCAN
- ULTRASOUND
- NUCLEAR MEDICINE
- MRI
- INTERVENTIONAL PROCEDURES

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