



PATIENT DETAILS

NAME:

DOB:

ADDRESS:

DIAGNOSTIC SERVICES REQUESTED

Reason for Referral and Clinical History

Recent Se Creatinine level (if patient requires IV contrast).....

REFERRING DOCTOR

SIGNATURE:

DATE:

IRG adheres strictly to the requirements of the Privacy Legislation regarding your Medical Information. Your signature here authorises IRG to provide your medical images and reports to other Medical Professionals whom you consult, and who may wish to view these as part of your medical care.

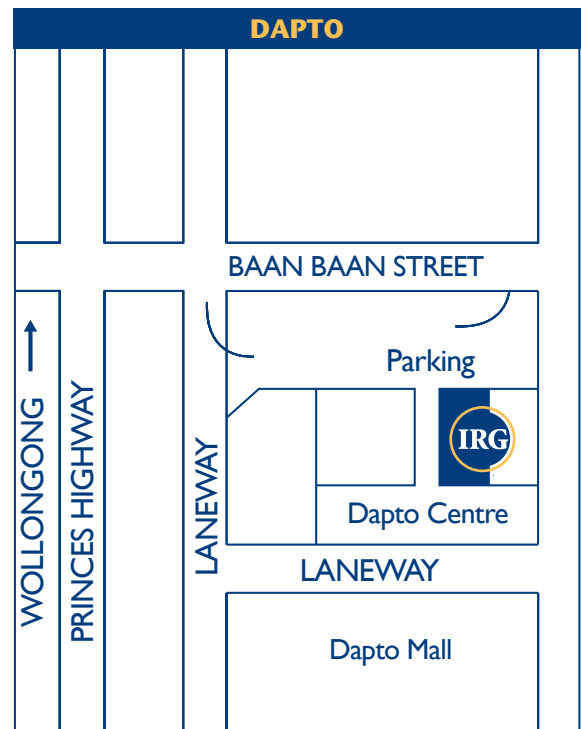
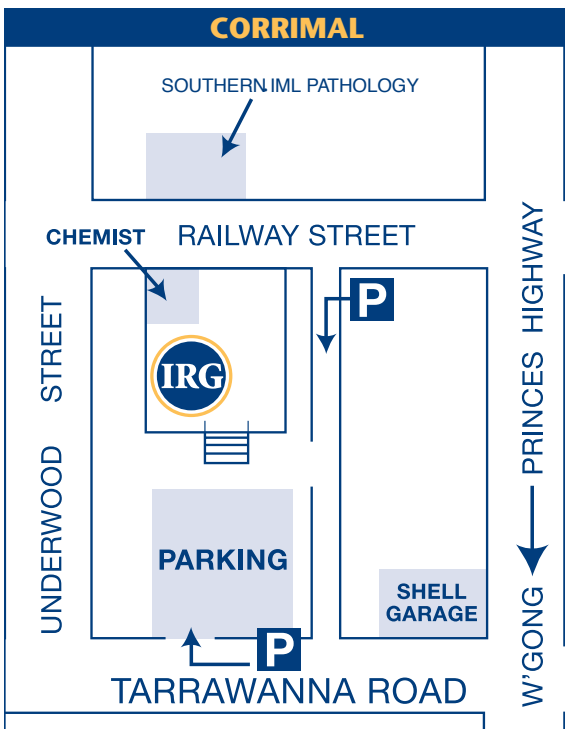
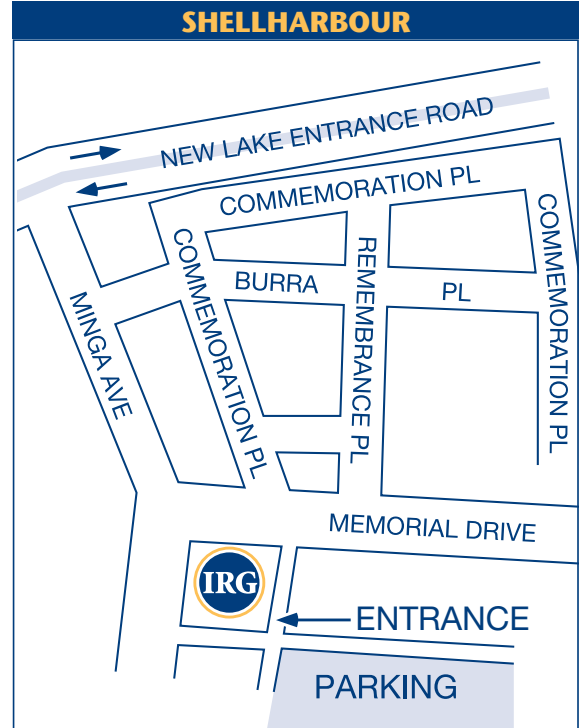
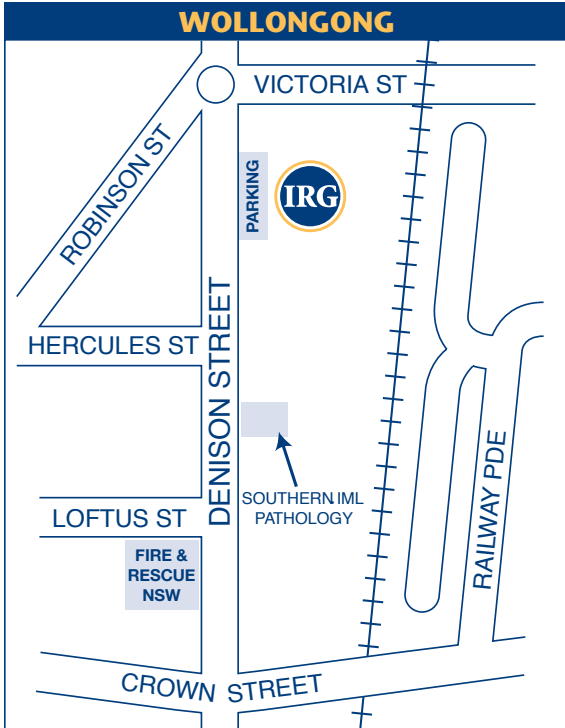
Order more referral pads – Fax 9806 0077

Patient Signature:

PLEASE BRING YOUR REQUEST FORM, PREVIOUS SCANS AND X-RAYS

PRACTICES

				OPEN WEEKENDS	EOS IMAGING	X-RAY	OPG & LATERAL CEPHALOMETRY	INTERVENTIONAL PROCEDURES	CT SCAN	MAMMOGRAPHY (with Tomosynthesis)	ULTRASOUND	ELASTOGRAPHY	MRI
WOLLONGONG	21-23 Denison Street	Ph: 02 4254 6900	Fax: 02 4227 1409	SAT AM	✓	✓	✓	✓	✓	✓	✓	✓	✓
SHELLHARBOUR	Level 1, 7 Minga Avenue	Ph: 02 4295 8600	Fax: 02 4296 3188			✓	✓	✓	✓		✓	✓	✓
CORRIMAL	83 Railway Street	Ph: 02 4268 7300	Fax: 02 4285 3186			✓	✓				✓		
DAPTO	47-51 Baan Baan Street	Ph: 02 4251 5900	Fax: 02 4262 1004			✓	✓	✓	✓		✓	✓	✓



MRI available by appointment after hours and on weekends

Your doctor has recommended you use IRG. You may choose another provider but please discuss this with your doctor first.