



**REQUEST/REFERRAL**

**RADIOLOGISTS:**

Drs Risto Nikolich, Deborah Raper, Amey Aurangabadkar, Kevin Wanambiro

**PATIENT DETAILS**

SURNAME

*Please Print*

GIVEN NAME

DATE OF BIRTH

..... / ..... / .....

**DIAGNOSTIC SERVICES REQUESTED** (Please tick box)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> EOS Full Spine                           | <input type="checkbox"/> EOS Full Spine + Lower Limbs | <input type="checkbox"/> EOS Pelvis + Lower Limbs |
| <input type="checkbox"/> General X-Ray                            | <input type="checkbox"/> OPG                          | <input type="checkbox"/> Lateral Cephalogram      |
| <input type="checkbox"/> CT                                       | <input type="checkbox"/> CT Angiography               |   |
| <input type="checkbox"/> Ultrasound                               | <input type="checkbox"/> Elastography                 |   |
| <input type="checkbox"/> Mammography (with Tomo)                  | <input type="checkbox"/> Mammogram +/- Ultrasound     |   |
| <input type="checkbox"/> FNA                                      | <input type="checkbox"/> Biopsy (Core)                | <input type="checkbox"/> Interventional Procedure |
| <input type="checkbox"/> MRI                                      |   |   |
| <input type="checkbox"/> Order more referral pads – Fax 9806 0077 |   |   |

**REFERRING PRACTITIONER:**

Region

**DOCTOR'S SIGNATURE AND REQUEST DATE**

**X** THE REQUEST NEED NOT BE HAND WRITTEN BUT BY LAW MUST BE SIGNED BY PRACTITIONER

..... / ..... / ..... DATE

PHONE REPORT NO.

FAX REPORT NO.

CC DOCTOR .....

Reason for Referral and Clinical History

06/20

Recent Se Creatinine level (If patient requires IV Contrast).....

Illawarra Radiology Group adheres strictly to the requirements of the Privacy Legislation regarding your Medical Information. Your signature here authorises Illawarra Radiology Group 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. Patient Signature: .....

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

**PLEASE BRING 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
<b>WOLLONGONG</b>	21-23 Denison Street	<b>Ph: 02 4254 6900</b>	Fax: 02 4227 1409		✓	✓	✓	✓	✓	✓	✓	✓	✓
				<b>SAT AM</b>	✓	✓	✓		✓				✓
<b>SHELLHARBOUR</b>	Level 1, 7 Minga Avenue	<b>Ph: 02 4295 8600</b>	Fax: 02 4296 3188			✓	✓	✓	✓		✓	✓	✓
<b>CORRIMAL</b>	83 Railway Street	<b>Ph: 02 4268 7300</b>	Fax: 02 4285 3186			✓	✓				✓		
<b>DAPTO</b>	47-51 Baan Baan Street	<b>Ph: 02 4251 5900</b>	Fax: 02 4262 1004			✓	✓	✓	✓		✓	✓	✓

