

Appointment date: / /

Appointment time:

Please bring your Medicare card, previous x-rays and scans.

Patient details

Name: _____ DOB: / /

Phone:

Procedure Requested: *Please tick or write below*

- | | |
|--|---|
| ☐ Bone scan | ☐ Lymphoscintigraphy (extremities) |
| ☐ Body composition DEXA | ☐ Gastric emptying |
| ☐ Bone mineral density (BMD) DEXA | ☐ Gastric reflux |
| ☐ Persantin myocardial perfusion | ☐ Oesophageal transit |
| ☐ Lung scan (V/Q) | ☐ Gated heart pool |
| ☐ Lung quantitation | ☐ Bone marrow |
| ☐ Hepatobiliary scan (HIDA) | ☐ Parathyroid |
| ☐ Renal scan - DTPA, MAG3, DMSA | ☐ Thyroid |
| ☐ (indicate) | ☐ Liver/spleen |
| ☐ Cerebral Perfusion | ☐ Other: |

Clinical notes

[illegible]

Referring Doctor These sections **MUST** be completed

Name: _____ Provider No: _____

Address: _____ Speciality: _____

Phone:

Fax:

Email:

Signature: _____ Date: _____

Date: _____