

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

☐ Body composition DEXA

☐ Bone Mineral Density DEXA

☐ Pharmacological myocardial perfusion

☐ Lung scan (V/Q)

☐ Lung Quantitation

☐ Hepatobiliary (HIDA)

☐ Renal - indicate - DTPA or MAG 3 or DMSA

☐ Cerebral Perfusion

☐ Lymphoscintigraphy

☐ Gastric emptying

☐ Gastric reflux

☐ Oesophageal transit

☐ Colonic transit

☐ Gated Heart pool

☐ Bone marrow

☐ Parathyroid

☐ Thyroid

☐ Others: _____

Clinical notes

Referring Doctor These sections **MUST** be completed

Name:

Provider No:

Address:

Speciality:

Phone:

Fax:

Email:

Signature:

Date: