



melbournradiologyclinic

chiropractic & osteopathic referral

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 melbournradiology.com.au

PATIENT DETAILS

Name: _____

Date of Birth: _____ Medicare No: _____

Address: _____

Phone: _____

EXAMINATION REQUESTED

Cervical Spine

- AP
- OM
- Neutral & Lateral
- Obliques
- Flexion & Extension

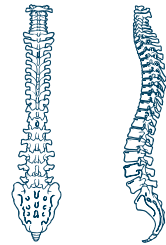
Thoracic Spine

- AP
 - Lateral
- #### Lumbar Spine
- AP (inc. pelvis)
 - Lateral Spot Lateral

Full Spine

- AP (inc. pelvis)
- Lateral
- MRI

CLINICAL DETAILS



ALERTS

Pregnant Y N LNMP _____

FOR MRI: ± X-ray orbits ± Skull ± CXR ± AXR.

Pacemaker? Y N Cochlear Implant? Y N Aneurysm Clip? Y N

REFERRER DETAILS

Name: _____

Address: _____

Provider no: _____

Signature: _____

Date: _____ **COPIES TO:** _____

PATIENT

- Private
- Pension
- VetAffairs
- WorkCover
- TAC

REPORT

- Return with patient
- Telephone
- Fax
- Email

MORE REFERRAL PADS

- A4 (computerised)
- A5 (manual)

Appointment Date & Time:

This form needs to be presented at the time of your appointment. Please bring your Medicare, DVA or current concession card and any previous scans with you.

PREPARATION FOR AN EXAMINATION

Unless otherwise advised, please continue to take your medications as usual. If you are diabetic, please advise us at the time of booking as fasting may be required for an examination.

DIGITAL X-RAY

No preparation required.

MRI SCAN

No preparation required.



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