



Please ensure that all sections are completed

Patient Information

Surname:.....

First name:.....

TLOC number:.....

Date of birth: / /

Address:.....

.....

.....

Postcode:.....

Telephone:.....

Male: Female:

Payment Details:

Insurance company:.....

Authorisation no.:.....

Membership no.:.....

Self paying:.....

Exam Required:

Please provide details of examination

Surgery/medications:

For females ages 12-55

Could you be pregnant? Yes No

LMP:.....

Patient signature:.....

Date: / /

Follow up appointment with specialist:

Date: / /

Referrer's name and address or stamp

Contact number:

Clinical Information:

Examination cannot be performed without sufficient clinical information (IRMER 2000)

THIS FORM IS A LEGAL DOCUMENT

Referrer's declaration:

The correct patient information has been provided. I have discussed the examination with the patient. I ensure the examination results are reported in the patient's notes.

Referrer's signature:.....

Date: / /

Radiology Appointment:

Date: / /

Time:.....

Radiologist Details:

Radiologist:.....

Date:..... / /