

# REQUEST FOR ELECTRONIC IMAGE TRANSFER

*I certify that the studies I am requesting below are required for the ongoing clinical management of the patient indicated. I have obtained the patient's consent to obtain prior imaging.*

Name\*:

Department\*:

Phone\*:

Email\*:

Date required to complete imaging transfer by:

AUTHORISATION

First Name\*:

Last Name\*:

Medicare No:

DOB\*:

PATIENT

## IMAGE TRANSFER DETAILS:

Imaging from\*: (Company and Site Name)

Imaging to\*:

Studies required to transfer\* (Modality and Date if known) :

### Exact Radiology

- Gatton
- Plainland
- Springfield
- Ipswich North
- Ipswich South

Exact Express (All)

Truescan Radiology

Lakes Radiology

Dr Glenn and Partners Kogarah

Dr Glenn and Partners Rockdale

Dr Glenn and Partners Wollongong

F: 07 3319 4664 (All)

F: 07 3112 1903

F: 02 9726 2399

F: 02 4973 3823

F: 02 9587 7147

F: 02 9567 4150

F: 02 4243 4099

### Radiology Queensland Group

- Chapel Hill
- Oxley
- Inala
- Underwood
- Sunnybank

Coastal Medical Imaging

Bayside Radiology

Bolsover Radiology

Bundaberg Radiology

Beachside Radiology

Clearview Medical Imaging

F: 07 3319 4664 (All)

F: 07 5413 5050

F: 07 4197 6622

F: 07 4930 7522

F: 07 4150 0222

F: 02 6691 7822

F: 02 8322 4091