



PATIENT DETAILS

Name* _____ DOB* _____

Address* _____

Contact Number* _____ Workers Comp

Medicare Number _____ Third Party

EXAMINATION REQUESTED

<p>FULL MEDICARE REBATE <u>Requested by Podiatrist</u></p> <p><input type="checkbox"/> X-Ray Foot L / R</p> <p><input type="checkbox"/> X-Ray Ankle L / R</p> <p><input type="checkbox"/> X-Ray Knee L / R</p> <p><input type="checkbox"/> X-Ray Lower Leg L / R</p> <p><input type="checkbox"/> US Mid/Forefoot L / R</p> <p><input type="checkbox"/> US Ankle/Hindfoot L / R</p> <p><input type="checkbox"/> US of Mass</p>	<p>FULL MEDICARE REBATE <u>Requested by Osteo & Physio</u></p> <p><input type="checkbox"/> X-Ray Cervical Spine</p> <p><input type="checkbox"/> X-Ray Thoracic Spine</p> <p><input type="checkbox"/> X-Ray Lumbar Spine</p> <p><input type="checkbox"/> X-Ray Sacrococcygeal</p> <p><input type="checkbox"/> X-Ray Hip</p> <p><input type="checkbox"/> X-Ray Pelvis</p>	<p>REDUCED MEDICARE REBATE <u>Requested by all Allied Health</u></p> <p><input type="checkbox"/> X-Ray Region (Other): _____</p> <p><input type="checkbox"/> Ultrasound Region: _____</p> <p><input type="checkbox"/> MRI (no rebate): _____</p> <p><input type="checkbox"/> Other Examination: _____</p>
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AREA TO BE EXAMINED & CLINICAL NOTES

Allergies _____ Urgent

For IV contrast exams, recent creatinine level / eGFR: _____

REFERRER DETAILS

Name* _____ Speciality* _____

Address* _____ Provider Number* _____

Contact Number* _____ Fax Number: _____

*Must be completed

Signature* _____ Date* _____

All reports and images are available electronically (via IntelRad and/or downloads).
Please tick below for your additional requests. Referral Pads Required

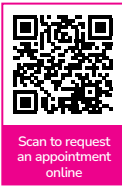
REPORTS Urgent Results Fax Download Phone Film Copy reports to:

- X-RAY/OPG:** No appointment or preparation required.
- CT:** You will receive instructions before your appointment.
- ULTRASOUND ABDOMEN:** Fast for 8 hours, nothing to eat, drink, chew or smoke prior to appointment. Small sips of water and medication allowed.
- ULTRASOUND PELVIS/KUB & OBSTETRIC:** Must present with full bladder, we suggest drinking 1L of water to be completed 1 hour prior to appointment time. Further instructions to be provided.
- ECHOCARDIOGRAPHY:** No preparation.
- MAMMOGRAPHY:** Do not wear perfume, deodorant or powder before your exam. A two-piece outfit is preferred, as you will need to remove everything from the waist up.
- MRI:** As advised by booking clerk.

Appointment Date: _____

Appointment Time: _____

Preparation Notes: _____



	Xray	Ultrasound	Nuchal Translucency	Echocardiography	Bone Density Study (BMD)	Mammography	Dental/OPG	Dentascans	CT	CT Virtual Colonoscopy	CT Calcification Scoring & Cardiac Angiography	Long Leg Imaging	Interventional Radiology & Pain Management	MRI
Gatton	●	●		●			●		●				●	
Plainland	●	●							●					
Ipswich (North)	●	●	●	●	●	●	●	●	●	●	●	●	●	
Ipswich (South)	●	●		●					●				●	●
Springfield Lakes	●	●	●	●			●	●	●		●		●	



Exact Radiology

CLINICS

GATTON:

18 William St, Gatton
Tel: 07 5462 3211
Fax: 07 5462 3244
Email: gatton@exactradiology.com.au

PLAINLAND:

Shop 12 Plainland Plaza,
 3 Gehrke Rd, Plainland
Tel: 07 5317 6050
Fax: 07 5317 6051
Email: plainland@exactradiology.com.au

IPSWICH (NORTH):

Riverlink Shopping Centre,
 2 The Terrace, North Ipswich
Tel: 07 3281 9051
Fax: 07 3281 9403
Email: ipswich.north@exactradiology.com.au

IPSWICH (SOUTH):

University of Southern
 Queensland, Building 5,
 11 Salisbury Rd, Ipswich
Tel: 07 3894 9755
Fax: 07 3894 9788
Email: ipswich.south@exactradiology.com.au

SPRINGFIELD LAKES:

Spring Lake Metro Shopping Centre,
 1 Springfield Lakes Blvd
 Springfield Lakes
Tel: 07 3436 0600
Fax: 07 3288 1688
Email: springfield@exactradiology.com.au