BLACKROCK HEALTH

BLACKROCK CLINIC

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Radiology Booking Form

PATIENT DETAILS

(Please Print)

Name: _____ Date of Birth: _____/_____/_____

Address: _____

Phone: _____ Email: _____ BRC MRN: _____

ED: ☐ GP: ☐ CON: ☐ IN-PATIENT: ☐ Ward: _____ Room: _____

Appears at risk of falling: ☐ Patient Infection Status: _____

Previous Imaging in BRC: Yes ☐ No ☐ Pacemaker / ICD: No ☐ Yes ☐ Details _____

Health Insurance: Yes ☐ No ☐ Insurer: _____ Policy No: _____

Public Patient: Yes ☐ No ☐ Hospital PO /UAN number: _____

Imaging Required: MRI ☐ CT ☐ US ☐ X-ray ☐ Nuc Med ☐ PAC ☐

Examination Required: _____

Clinical Indication: _____

_____

_____

Scan required: Urgent ☐ Next available ☐ Future date (please specify):_____

Referrer's Name: _____ Reg No: _____

(Please Print)

Referrer's Signature: _____ Date: _____

Referrer's Address: _____

_____

RADIOLOGY USE ONLY

RADIOGRAPHER:	DOSE METRIC:	DATE:

PLEASE ENSURE THE REQUEST FORM IS FULLY COMPLETED, SIGNED AND DATED

INCOMPLETE REQUESTS WILL NOT BE ACCEPTED AND WILL CAUSE PATIENT DELAYS