CT RADIOLOGY REQUEST

IANZ ACCREDITED RADIOLOGY SERVICE

Pacific Radiology

For Referrer to Complete

Patient Information Mr / Mrs / Ms / Miss M ☐ F ☐

Surname _____ First Names _____

DOB ____ /____ /____ NHI _____

Address _____ Mobile _____

_____ Phone _____

Email _____

Funding

☐ Patient Funded ☐ Accredited Employer - Name _____

☐ ACC - ACC number _____ ☐ Insurance Company - Name _____

Date of Injury ____ /____ /____ Insurance - Membership No. _____

Examination Requested _____

Relevant/Previous Imaging done at _____ Preferred Site: Dunedin / Kawarau Park / Invercargill

Clinical Details

☐ **Urgent** ☐ Semi urgent ☐ Non urgent Specific date request _____

Intravenous Contrast. For examinations requiring intravenous contrast if patient is over 70 or has known renal impairment or is a Diabetic, then Renal Function tests within the last 3 months and patient weight are required

Creatinine or eGFR Date ____ /____ /____ Weight _____

Precautions: _____

☐ Previous Contrast Reaction, details _____

☐ Known Renal Impairment ☐ Diabetic ☐ CT Injectable Power Port

Referrers Details

Signed _____

Name _____

Date ____ /____ /____

Copies of results to _____

Practice Stamp

For Radiology use only

Pregnancy Status ☐ Pregnant ☐ Not Pregnant MRT initials Checked with Radiologist Yes / No

Protocol Details ☐ Prehydration ☐ Steroid

Appointment Details: Date _____ Time _____ Place _____ email/post/phone

SX: Applied Code(s) _____ Comrad Code(s) _____ Surcharge $ _____

Pacific Radiology

THE MARINOTO CLINIC, DUNEDIN

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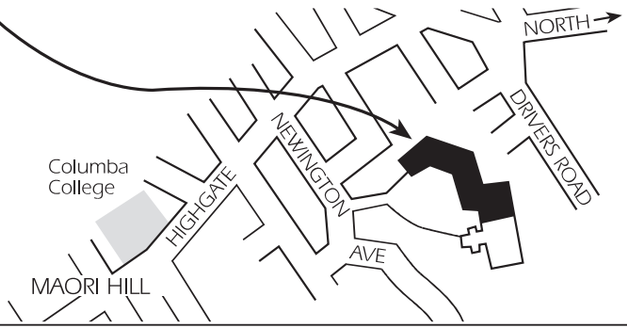
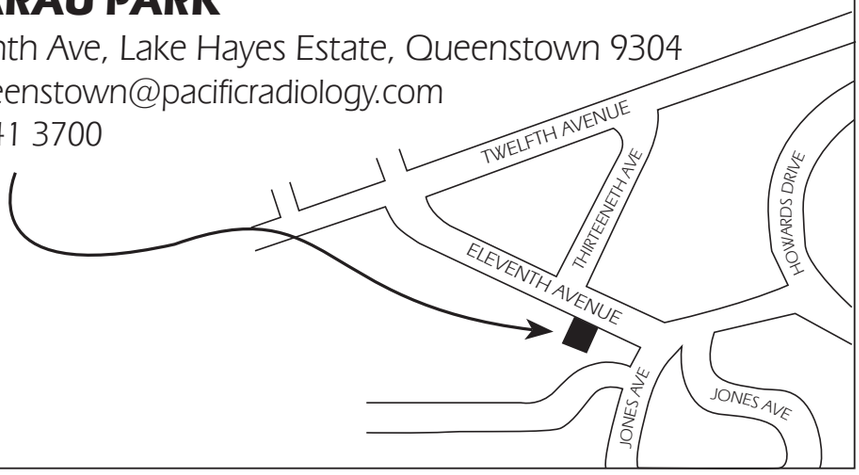


KAWARAU PARK

24 Eleventh Ave, Lake Hayes Estate, Queenstown 9304
Email queenstown@pacificradiology.com
Ph (03) 441 3700



INVERCARGILL RADIOLOGY

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