BLACKROCK HEALTH

BLACKROCK CLINIC

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Radiology Booking Form

PATIENT DETAILS

(Please Print)

Title: __________ First Name: __________________________ Surname: __________________________

DOB: _____/_____/________ Sex: ________________ BRC MRN: __________________

Address: ____

Phone: __________________________ Email: ___________________________________

ED: ☐ GP: ☐ CON: ☐ IN-PATIENT: Room: _________ Previous Imaging: Yes ☐ No ☐

Patient Infection Status: ___________ Pacemaker / ICD: Yes ☐ No ☐ Details _______________

Falls Risk Score: ____________ Bed ☐ Chair ☐ Walking ☐ Portable ☐

Health Insurance: Yes ☐ No ☐ Insurer: __________________ Policy No: ____________________

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

Interventional Radiology - Sample Required: YES ☐ NO ☐ INR: ______ FASTING: YES ☐ NO ☐

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: ____ IMC no: ___________

(Please Print)

Referrer's Signature: ____________________________________ Date: _____/______/________

Referrer's Address: ____
(If outpatient)

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