Mater Private Network

REFERRAL FOR DIAGNOSTIC IMAGING CENTRE

Surname		Male		Female	
Forename		Ward:			
Date of Birth	/ /	Walk		Trolley/Bed	
		Wheelchair		Portable	
Address					
MRN		Alert/Infection Risk:			
Primary Consultant		Allergies:			

Modality Requested (Please tick)			
Plain X-Ray		Mammography	
CT		DEXA	
Ultrasound		MRI	
Nuclear Medicine		PET/CT	
Interventional Radiology		Other	

Exam Required:

Clinical Question to be Answered:

Previous Investigations	**Previous Operations**

Female Patients of Childbearing Age (12 – 55 years)				
First day of Last Menstrual Period (LMP): / /				
Pregnancy Declaration Form completed	**Yes**		**No**	

Referring Clinician (please print)	
Medical Council Number	
Signature	
Date	