REFERRAL REFERRAL REFERRAL REFERRAL REFERRAL REFERRAL

PATIENT DETAILS

Date: _____

Name: _____

DOB: _____ Phone: _____

Address: _____

_____

Medicare No: _____ Exp: _____

EXAMINATION & CLINICAL NOTES

Please tick the appropriate boxes

☐ X-Ray ☐ CT ☐ MRI (new) ☐ Ultrasound ☐ DEXA ☐ Injection Only

☐ Scan (CT / US) **plus** injection/aspiration, if indicated.

SHOULDER ULTRASOUND

- Assess tendon / Muscle ☐
- Rotator cuff tear / Tendinosis / Calcification ☐
- Biceps Subluxation ☐
- Capsulitis / Bursitis ☐
- Mass / Ganglion ☐
- Occult # ☐
- AC joint ☐

KNEE ULTRASOUND

- Tendon / Bursae ☐
- Meniscal tear, baker's cyst mass OR pseudomass ☐
- Nerve entrapment / Tumour ☐
- Collateral ligament injury ☐

For IV contrast, recent Creatinine level ..... eGFR .....

COPY REPORT TO

REFERRING DOCTOR

Name: Date:

Provider No:

Address:

Phone:

Signature:

InFocus RADIOLOGY

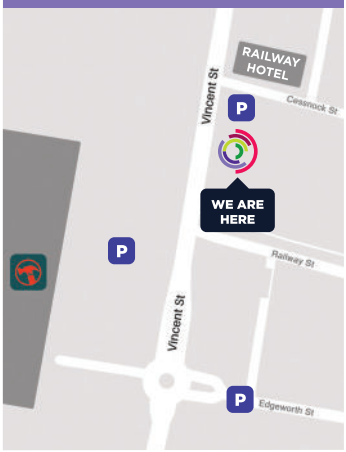
WARNERS BAY 4915 7477 | **BELMONT** 4911 9100 | **CESSNOCK** 4013 5111

OPENING HOURS MON - FRI: 8AM – 5PM

WARNERS BAY
9/472 The Esplanade,
Warners Bay NSW 2282
Fax: 4915 7476

BELMONT
545 Pacific Highway,
Belmont NSW 2280
Fax: 4945 0718

CESSNOCK
1 Cessnock Street,
Cessnock NSW 2325
Fax: 4013 5088



YOUR APPOINTMENT DETAILS

Time: _____ Date: _____

Preparation: _____

OUR SERVICES

	Warners Bay	Belmont	Cessnock
MRI			●
X-ray	●	●	●
Ultrasound	●	●	●
CT (Including Angiogram)	●	●	●
CT Colonography			●
CT Calcium Score		●	
Bone Density		●	●
OPG/Dental	●	●	●
Guided US Injections	●	●	●
Guided CT Injections	●	●	●
Biopsies	●	●	●

***All Medicare eligible services BULK BILLED** *(excluding core biopsy)*

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NATA