

Radiology Referral Information

Patient's Surname _____ D.O.B. _____

First names _____ Phone _____

Address _____ NHI _____

_____ Date _____

Referrer _____ Copy to _____

Signature _____ **Report:** Routine Urgent fax Urgent phone

NZMC No: _____ NCNZ No: _____

ACCIDENT? YES NO ACC N^o. _____

Covered by: ACC or Accredited Employer _____
Name of employing company

PREGNANCY SCANS LMP _____ EDD _____

Clinical Indication Code for this scan (See list on inside of cover) _____

Must be completed in all cases

Are you: the LMC the O&G Specialist Other if Other, select **one** of the following
 The gestational age is under 15 weeks Scan qualifies as an emergency scan - after 15 weeks

I am the back-up for the LMC. Name of LMC _____

The scan is outside Section 88 and patient pays full charge

Clinical

Examination Requested? _____

What is the Clinical Question? _____

FOR IVU'S AND CT SCANS (Please circle your answer)

Is there a history of diabetes? Yes / No

Is there a history of renal impairment? Yes / No

Is there a history of previous contrast reactions? Yes / No

What is the serum creatinine? _____

Practice Stamp

HOW TO CONTACT US, HOURS OF OPENING, LOCATION



Appointment Enquiries: (03) 548 2745

Email: admin@nelsonradiology.co.nz

Fax: (03) 546 7284

Hours of Business: 8.00am - 5.30pm Monday to Friday

Location: 211 Bridge Street, Nelson, 7010



YOUR X-RAY REPORT

After your examination has been completed, the images will be examined by a radiologist and a written report will be sent to your doctor. You should contact your doctor if you wish to discuss the results.