Voxel Radiology

1A Powers Street

(07) 4181 0200

PATIENT

Patient Name:

Age: Sex:

Date of birth:

Address:

☐ This is a work cover claim

Medicare:

Mobile:

IMAGING REQUEST

URGENCY

◯ Urgent

◯ Routine

◯ Other_____

REGION OF INTEREST AND PROCEDURE

Is the patient pregnant ◯ Yes ◯ No ◯ Unsure ◯ Not applicable

Is the patient is diabetic ◯ Yes ◯ No

Referring practitioner:

Name:

Contact details:

Signed Date / /

Alert CT

◯ Renal imparment eGFR:_____

◯ Contrast allergy

◯ Diabetes

◯ Metformin

◯ Grave's disease

Alert MRI

◯ Pacemaker

◯ Neuro/Bio stimulant

◯ History of metal work/welding

◯ Medication patches

MRI, CT, Ultrasound, Mammography & X-ray