Voxel Radiology

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PATIENT

Patient Name: _____ ☐ This is a work cover claim

Date of birth: _____ Medicare: _____

Address: _____ Phone: _____

EXAMINATION

◯ X-Ray ◯ Ultrasound ◯ Mammogram ◯ Interventional

◯ CT ◯ MRI ◯ X-ray orbits

REGION OF INTEREST: _____

URGENCY

◯ Urgent
◯ Routine
◯ Other_____

CLINICAL HISTORY

_____

_____

_____

_____

_____

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

Is the patient is diabetic ◯ Yes ◯ No

Referring practitioner:

Name:

Contact details:

Signed Date / /

COPIES TO:

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