

<input type="radio"/> MR <input type="radio"/> MRS <input type="radio"/> MS <input type="radio"/> MISS <input type="radio"/> DR	SURNAME	FIRST NAME
ADDRESS		DOB / /
		NHI #
EMAIL		ACC #
PHONE (HOME)	PHONE (MOBILE)	INSURER #

3T MRI	3T MRI	XRAY	CT	ULTRASOUND
<input type="radio"/> C Spine <input type="radio"/> T Spine <input type="radio"/> L Spine <input type="radio"/> SIJ <input type="radio"/> Shoulder <input type="radio"/> Neck <input type="radio"/> Elbow <input type="radio"/> Wrist <input type="radio"/> Finger/Thumb <input type="radio"/> Pelvis <input type="radio"/> Hip <input type="radio"/> Knee <input type="radio"/> Ankle <input type="radio"/> Foot <input type="radio"/> Arthrogram <input type="radio"/> Brain	<input type="radio"/> Angiogram <input type="radio"/> Chest <input type="radio"/> Abdomen <input type="radio"/> Other _____ INTERVENTION <input type="radio"/> Steroid Injection <input type="radio"/> PRP Injection <input type="radio"/> Nerve Root Injection <input type="radio"/> Facet Joint Injection <input type="radio"/> Biopsy <input type="radio"/> Other _____ <input type="radio"/> Radiofrequency Ablation	<input type="radio"/> General <input type="radio"/> Other _____ NUCLEAR MEDICINE (GRAFTON ONLY) <input type="radio"/> Bone SPECT-CT <input type="radio"/> Whole Body Bone scan <input type="radio"/> Other _____ EOS (GRAFTON ONLY) <input type="radio"/> Spine <input type="radio"/> Lower limb <input type="radio"/> Whole body	<input type="radio"/> Musculoskeletal Spine <input type="radio"/> Musculoskeletal Other _____ <input type="radio"/> Head <input type="radio"/> Angiogram <input type="radio"/> Sinus <input type="radio"/> Neck <input type="radio"/> Chest <input type="radio"/> Abdomen <input type="radio"/> Pelvis <input type="radio"/> Other _____ BREAST IMAGING (SILVERDALE ONLY) <input type="radio"/> Mammo <input type="radio"/> MRI <input type="radio"/> Biopsy <input type="radio"/> Ultrasound <input type="radio"/> Other _____	<input type="radio"/> Musculoskeletal ± X-Ray <input type="radio"/> Injection <input type="radio"/> Aspiration <input type="radio"/> Upper abdomen <input type="radio"/> Renal <input type="radio"/> Pelvis <input type="radio"/> Obstetrics <input type="radio"/> Carotid <input type="radio"/> DVT <input type="radio"/> Other _____

REGION OF INTEREST / PROCEDURE:	ALERTS	URGENCY
	<input type="radio"/> Renal Impairment eGFR _____ <input type="radio"/> Contrast Allergy <input type="radio"/> Anticoagulants <input type="radio"/> Pacemaker <input type="radio"/> Neuro/Biostimulator <input type="radio"/> Other _____	<input type="radio"/> URGENT <input type="radio"/> Routine <input type="radio"/> Other _____
	Is the Patient a Diabetic? <input type="radio"/> Yes <input type="radio"/> No Is the Patient Pregnant? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unsure <input type="radio"/> N/A	
CLINICAL DETAILS		

REFERRING PRACTITIONER	
NAME	POSITION
CONTACT DETAILS	
NZMC #	
SIGNED	PATIENT FOLLOW UP APPOINTMENT: DATE / /
DATE / /	

I WOULD LIKE A COPY OF THE REPORT SENT TO:

As a consumer, you have the right to choose any Radiology provider for your imaging.

1 LONDON STREET, HAMILTON CENTRAL, HAMILTON 3204



BY VEHICLE, limited FREE patient parking is available at 1 London Street. Please use designated patient parking areas only

Free Overflow Parking: Secure Parking, 19 London Street (100m/2-min walk). Use designated Beyond Radiology car spaces only.

Hamilton Transport Centre (500m/5-10min walk away) is situated at the bottom left of map.



ALL PATIENTS: Please bring any previous relevant medical imaging with you to your appointment.