ABSOLUTE RADIOLOGY
Specialist Radiology Services

DATE

PATIENT SURNAME		ADDRESS	
FIRST NAME			
MIDDLE NAME		PH	
D.O.B	GENDER	EMAIL	
NHI#		Is your patient pregnant?	EDD
PRIORITY ☐ URGENT ☐ SAME DAY ☐ ROUTINE		☐ YES ☐ NO	LMP

INSURANCE#	ACC#
PROVIDER	PRIVATE PAYMENT ☐ YES ☐ NO
WORK RELATED ☐	WORKPLACE INSURER

	MRI	CLINICAL DETAILS
	CT	
	X-RAY	
	ULTRASOUND	
	BONE DENSITY SCAN	
	INTERVENTIONAL RADIOLOGY ☐ USS GUIDED ☐ CT GUIDED	
	FLUOROSCOPY	
	BODY COMPOSITION	*Follow up appointment date*

Region of Interest

MRI	Does your patient have a Cardiac Pacemaker? ☐ YES ☐ NO	Patient height _____ Patient Weight _____
	Does your patient require? ☐ SEDATION ☐ GENERAL ANAESTHETIC	

Does your patient have any impairments or mobility concerns we should be aware of? ☐ YES ☐ NO
If yes, please specify:

REFERRER NAME	MCNZ#	SEND REPORT ☐ EDI ☐ FAX
PH	COPIES TO	

DUE TO CONFIDENTIALITY CONCERNS & MAIL DELIVERY RESTRICTIONS WE NO LONGER POST REPORTS.

PLEASE ENSURE YOUR HAVE INTELERAD ACCESS TO VIEW REPORTS

Fill in scan to email then send to bookings@absoluteradiology.co.nz

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