Pacific Radiology

Southern Cross Health Society Affiliated Provider

Patient's Name .....

Address..... DOB.....

..... NHI#.....

..... Tel (mob).....

Email..... Tel (hme).....

ACCIDENT ☐ YES ☐ NO ACC No. ..... Date of injury .....

COVERED BY: ☐ ACC ☐ Accredited Employer.....

[name of employing company]

MEDICAL INSURANCE? ☐ YES ☐ NO Provider..... Policy #.....

PREGNANCY SCANS: LMP ..... (unsure ☐) or EDD ..... (by Scan ☐ LMP ☐ Other ☐)

Clinical Indication Code ..... *(see inside cover)* Is the patient eligible for health benefit? ☐ YES ☐ NO

☐ **X-RAY**

☐ **FLUOROSCOPY**

☐ **ULTRASOUND (US)**

☐ **CONE BEAM CT**

☐ **CT**

☐ **MRI**

☐ **MAMMOGRAPHY**

☐ **BONE DENSITY**

☐ **PET-CT (MSK ONLY)**
All other scans use dedicated PET/CT form

REGION OF INTEREST/EXAMINATION

CLINICAL DETAILS:

IMPORTANT - REFERRING CLINICIAN

Is the patient diabetic? ☐ Yes ☐ No

PRIOR TO MRI:

Patient has a cardiac pacemaker

☐ Yes ☐ No

Approx weight.....kg Height.....

DOES YOUR PATIENT REQUIRE:

Sedation ☐ Yes ☐ No

General Anaesthetic ☐ Yes ☐ No

RESULTS:

Report Priority ☐ Urgent ☐ Routine **Report** ☐ EDI ☐ Fax ☐ InteleConnect only

☐ Phone Me Mobile Ph .....

Referring practitioner:.....

Signature: .....

NZMC/MCONZ #: ..... Date: .....

ACC Provider #:..... ☐ Send more forms

Copy of report to: .....