Medical Imaging Referral

The Royal Children's Hospital Melbourne

Families may choose any imaging provider - this should be discussed with the referring doctor

Patient name _____ DOB _____

Address _____

Telephone _____

MRN _____

Medicare no. _____

◯ Please Bulk Bill

Print patient name if label used

AFFIX PATIENT LABEL HERE ↑

Examinations requested

_____

Reason for examination and relevant history _____

_____

_____

_____

Referrer details *(all fields mandatory)*

Referrer _____

Signature _____ **Date** _____

Provider number _____

Address _____

Telephone _____ **Fax** _____ **Email** _____

Image requirements

Images required: ◯ Transferred to RCH (image.transfers@rch.org.au) ◯ Send with patient

Report requirements *(only complete if different to default requirements setup for referrer)*

Report required: ◯ Urgently *(patient seeing doctor immediately)* ◯ Routine