Medical Imaging
Lower Ground – Underwater
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The Royal Children's Hospital Melbourne

REQUEST FOR PATIENT MEDICAL IMAGING

1. APPLICANT: Medical Officer ❑ Hospital ❑ Parent/Guardian ❑ Patient ❑

First Name: _____ Surname: _____

Address: _____

Telephone: _____ Fax: _____

(Patient requesting must be over 16 years of age)

Hospital/Organisation: _____ Provider No: _____

If Doctor: I am the current treating Doctor of the above patient and I require the information detailed below for the future treatment of the patient.

Signed: _____ Date: _____

2. PATIENT DETAILS:

First names: _____ Surname: _____

Date of Birth: _____ Unit Record Number: (if known)_____

Patient must be 16 years or older to request

3. IMAGING REQUESTED:

☐ All imaging ☐ Specific exams & dates (specify below)

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_____

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4. APPLICANT'S SIGNATURE: _____

DATE: _____

I certify that to the best of my knowledge that the above details are correct