

Patient Details

Name _____ Date of Birth _____

Address _____

Contact Details _____ Medicare No _____

Chiropractic / Physiotherapy (all examinations performed load bearing unless otherwise requested)

- | | | | | | |
|---|-----------------------------|--|----------------------------------|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> Long Spine Film | <input type="checkbox"/> AP | <input type="checkbox"/> Lat | | | |
| <input type="checkbox"/> C Spine | <input type="checkbox"/> AP | <input type="checkbox"/> AP Open Mouth | <input type="checkbox"/> Lat | <input type="checkbox"/> Oblique | <input type="checkbox"/> Flex / Ext |
| <input type="checkbox"/> T Spine | <input type="checkbox"/> AP | <input type="checkbox"/> Lat | | | |
| <input type="checkbox"/> L/S Spine (inc Pelvis) | <input type="checkbox"/> AP | <input type="checkbox"/> Lat | <input type="checkbox"/> Oblique | <input type="checkbox"/> Flex / Ext | |

Podiatry (all examinations performed load bearing unless otherwise requested)

- Left Right Bilateral

X-Ray

- | | | | |
|---|--|------------------------------|--|
| <input type="checkbox"/> Foot | <input type="checkbox"/> AP | <input type="checkbox"/> Lat | <input type="checkbox"/> Oblique |
| <input type="checkbox"/> Ankle | <input type="checkbox"/> AP | <input type="checkbox"/> Lat | <input type="checkbox"/> Mortise |
| <input type="checkbox"/> Knee | <input type="checkbox"/> AP | <input type="checkbox"/> Lat | <input type="checkbox"/> Intercondylar |
| <input type="checkbox"/> Femur (AP and Lat) | <input type="checkbox"/> Tibia / Fibula (AP and Lat) | | |

Ultrasound

- Ankle / Hindfoot Mid / Forefoot Lump

Dental

- OPG Lateral Cephalogram Mandible Dentascan
 TMJ's Frontal Cephalogram

Clinical Hx / Notes

Referred By _____ Provider Number _____

Contact Details _____

Signature _____ Date _____

Office use only	Name <input type="checkbox"/>	DOB <input type="checkbox"/>	Body Part <input type="checkbox"/>	Initial
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Your doctor has recommended that you use Lime Radiology. You may choose another provider but please discuss this with your doctor.

Appointment Date _____

Appointment Time _____

am
pm

Preparation Notes _____

Please bring your request form and any previous films to your appointment. If unable to keep this appointment, kindly give 24 hours notice.

GENERAL RADIOGRAPHY

General X-rays
 Long spine radiographs

MULTISLICE CT

General CT
(including multiplanar & 3D reconstructions)
 CT angiography
(excluding Coronary Angiography)
 CT pelvimetry
 CT lower limb measurements
 CT guided facet or nerve root injections
 CT dentascan

ULTRASOUND

General ultrasound
 Vascular ultrasound
Peripheral arteries
Renal arteries
Mesenteric arteries
Carotid duplex scanning
Venous studies including CVI mapping
 Obstetric ultrasound
1st trimester
Nuchal Translucency Assessment
Morphology scans
3D foetal ultrasound
3rd trimester
 Musculoskeletal ultrasound
(including ultrasound guided injections)
 Ultrasound guided biopsies
 Echocardiography

NUCLEAR MEDICINE

General Nuclear Medicine
 Myocardial perfusion studies
 Sentinel node studies
 I-131 (non-oncology) therapy

BREAST IMAGING

Digital mammography
 Breast ultrasound
 Ultrasound guided biopsies
 Ultrasound or mammography guided localisations
 Stereotactic biopsies and localisations

BMD

OPG

Digital OPG
 Lateral cephalograms

