PERTH RADIOLOGICAL CLINIC

PATIENT'S NAME: ..... PHONE: .....

ADDRESS: .....

..... DATE OF BIRTH: .....

RADIOLOGIST CONSULTATION REFERRAL

- ☐ **PLAIN FILM**
- ☐ **ULTRASOUND**
  - ☐ Renal ☐ Abdominal ☐ Liver ☐ Liver US & Elastography ☐ Pelvic ☐ Obstetric ☐ Other

  .....
- ☐ **CT**
- ☐ **MRI**
- ☐ **DOPPLER**
- ☐ **IMAGE GUIDED INJECTION**
- ☐ **BONE DENSITOMETRY** (DEXA)
- ☐ **BILATERAL MAMMOGRAM**
  - ☐ Single Breast or Bilateral Breast lump/s
  - ☐ Mass
  - ☐ Pain (Localised)
  - ☐ Tenderness (Localised)
  - ☐ Follow up of previous malignancy
  - ☐ Family History
- ☐ **BREAST ULTRASOUND** (BILATERAL)
- ☐ **BREAST ULTRASOUND** (ONE SIDE)
- ☐ **FNA**

SHOULDER ULTRASOUND

- ☐ Evaluation of injury to Tendon, Muscle or Muscle/Tendon Junction
- ☐ Rotator Cuff Tear/Calcifcation/Tendinosis
- ☐ Biceps Subluxation
- ☐ Capsulitis and Bursitis
- ☐ Evaluation of Mass including Ganglion
- ☐ Occult Fracture
- ☐ Acromioclavicular Joint Pathology

KNEE ULTRASOUND

- ☐ Abnormality of Tendons or Bursae about the Knee
- ☐ Meniscal Cyst, Popliteal Fossa Cyst, Mass or Pseudomass
- ☐ Nerve Entrapment, Nerve or Nerve Sheath Tumor
- ☐ Injury of Collateral Ligaments

MULTISLICE CT ARTHROGRAM

- ☐ Knee Meniscal & Cruciate Ligament tears
- ☐ Knee Assessment of Chondral Surfaces
- ☐ Other

CLINICAL DETAILS (Please send previous films)

TO BE COMPLETED BY REFERRING PRACTITIONER

DOCTOR'S SIGNATURE: ..... **PROVIDER NUMBER**..... **DATE OF REQUEST** .....

REFERRER ADDRESS: .....

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COPY TO.....

A4 STANDARD REFERRAL