Perth Radiological Clinic

Patient's Name ..... ☐ Private

Address ..... ☐ Workers' Comp

..... Phone ..... ☐ MVA

Date of Birth ..... Female Patients 12-50 yrs Date of L.M.P. .....

RADIOLOGIST CONSULTATION REFERRAL

☐ **Ultrasound**

- ☐ Abdominal
- ☐ Liver US & Elastography
- ☐ Liver
- ☐ Renal
- ☐ Pelvic
- ☐ Obstetric
- ☐ Other

☐ **Doppler** ☐ **Plain Film** ☐ **CT**

☐ **MRI** please specify region: .....

.....

☐ **Bilateral Mammogram / Tomosynthesis**

- ☐ Investigation of Breast Symptom/s or
- ☐ Past history of Breast Cancer or
- ☐ Family history of Breast or Ovarian Cancer or
- ☐ Routine screening, none of the above apply (no medicare rebate)

☐ **Breast Ultrasound** (bilateral)

☐ **Breast Ultrasound** (one side)

☐ **FNA**

☐ **Bone Densitometry** (dexa)

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

CLINICAL DETAILS **Previous studies available for comparison** No ☐ PRC ☐ Other ☐ Details .....

TO BE COMPLETED BY REFERRING PRACTITIONER

Referrer's Signature: ..... **Provider Number:** ..... **Date of Request:** .....

Referrer address: .....

Copy to .....

A4 STANDARD REFERRAL