## RADIOLOGY ALLIED HEALTH REQUEST FORM

Address:		
Suburb:	State:	Postcode:
FILMS TO BE TAKEN		(excluding C-Spine)
Unless specified, all examinations will b	pe performed erect.	Erect Suplne
MEDICARE ELIGIBLE EXAMINATION	REQUESTED	
Cervical Spine	Lumbar Spi	ne
AP AP Open Mouth Lateral: Neutral Lateral: Flexion/Extension Obliques Thoracic Spine AP Lateral	Lateral: Ne Lateral: Fle Obliques Pelvis Non-Medicare Eli Other Exam	le full pelvis and femoral heads)
	MRI	
		Date:
Address:	MRI	Date: Signature:
Address: Provider No:	MRI	
Referred by: Address: Provider No: Copy To: FILMS & REPORT	TECHNOLOGIS	Signature:
Address: Provider No: Copy To:	TECHNOLOGIS	Signature:
Address: Provider No: Copy To: FILMS & REPORT	TECHNOLOGIS  Patient Iden	Signature: ST USE ONLY
Address: Provider No: Copy To: FILMS & REPORT Post Fax (No.)	TECHNOLOGIS  Patient Iden Procedure / Site / Side ve	Signature:  ST USE ONLY  Intification verified

Your doctor has recommended that you use Radiant Radiology. You may choose another provider but please discuss this with your doctor first.