

RADIOLOGY DEPT.



Whanganui
District Health Board

URGENT
SEMIURGENT
NON URGENT.

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MISS _____
MRS _____
SURNAME (also known as) MR _____ DOB ____/____/____

CHRISTIAN NAMES _____

ADDRESS _____
HOME _____
PHONE No, WORK _____

SEX _____ REFERRING GP _____

Report to:
Consultant _____

Copies to:
Registrar _____
RMO _____

XRAY ULTRASOUND CT MRI

ACC ^{Claim}No. _____ NOT WORK RELATED WORK RELATED

INJURY MANAGER:

MAIN PRESENTING COMPLAINT AND CLINICAL HISTORY:

L.M.P. _____

Serum Creatinine

Date S. Cr. Taken / /

PROVISIONAL DIAGNOSIS or DIFFERENTIAL DIAGNOSIS

WHAT IS THE MAIN OBJECTIVE OF THIS EXAMINATION

SUGGESTED REGIONS TO BE EXAMINED:

Radiologist Requests
Contrast

Yes No

Signature _____ Title _____ Pager No: _____ Date: _____

RADIOGRAPHERS
COMMENTS

Radiographer:

All of the above sections must be completed with the appropriate information

18x24	24x30	30x40	35x43	18x43	35x35	OTHER	TOTAL