

# 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 \_\_\_\_\_

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Copies to:  
Registrar \_\_\_\_\_  
RMO \_\_\_\_\_

XRAY  ULTRASOUND  CT  MRI

ACC <sup>Claim</sup>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