MOKOIA RADIOLOGY

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Office use only

PLEASE PHONE FOR AN APPOINTMENT. A CHARGE WILL APPLY FOR ALL EXAMINATIONS.

APPOINTMENT

TIME: DAY: DATE:

Mr Mrs
Ms Miss

SURNAME

DATE OF BIRTH

FIRST NAMES

TELEPHONE (HM)

ADDRESS

TELEPHONE (BUS)

MOBILE

EMAIL ADDRESS

ACC NUMBER /NHI

X-RAYS

Pregnant ☐ Yes ☐ No ☐ Unsure

Referring Doctor

Signature Date

ULTRASOUND

- ☐ Pregnancy
- ☐ Abdomen
- ☐ Renal
- ☐ Pelvis
- ☐ Thyroid
- ☐ Breast ☐ L ☐ R
- ☐ Testes
- ☐ Carotid Doppler
- ☐ Musculo-Skeletal
- ☐ Leg Doppler
- ☐ Arterial ☐ L ☐ R
- ☐ Venous ☐ L ☐
- ☐ Leg DVT
- ☐ Echocardiography
- ☐ FNA
- ☐ Core Biopsy

CT SCANNING

- ☐ Brain
- ☐ IAM's/Temporal Bones
- ☐ Sinuses
- ☐ Neck
- ☐ Chest
- ☐ Abdomen/Pelvis
- ☐ Renal Colic
- ☐ Vascular Incl. AAA
- ☐ Other Regions
- ☐ High Resolution Chest
- ☐ Cardiac Angiogram
- ☐ Colonography
- ☐ _____

MRI

- ☐ Brain
- ☐ IAMS / ACOUSTIC
- ☐ Neck
- ☐ Cardiac
- ☐ Abdomen
- ☐ Pelvis
- ☐ MRCP
- ☐ MS Screen
- ☐ Extremity
- ☐ Spine _____
- ☐ MR Angiogram
  - ☐ Peripheral
  - ☐ Cerebral
  - ☐ Carotoid
  - ☐ Renal
- ☐ Other _____

Copy of reports to

Clinical details are required for all referrals.

Maternity Indication Code _____

Previous Scan Y/N

LMP _____

GRAVIDA _____

EDD from Scan _____

PLEASE BRING ANY PREVIOUS X-RAYS OR SCANS.