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### PATIENT DETAILS

Patient name: \_\_\_\_\_  
Birth date: \_\_\_\_\_  
Contact details: \_\_\_\_\_  
Medicare number: \_\_\_\_\_  
WorkCover claim number: \_\_\_\_\_

### PAEDIATRIC RADIOLOGISTS

Dr Andrew Butler  
Dr Sarah Cameron  
Dr Jonathan Corness  
Dr Craig Ferguson  
Dr Thomas Hess  
Dr David Kim  
Dr Jane McEniery  
Dr Jennifer Powell

### EXAMINATION REQUESTED

Examination requested: \_\_\_\_\_

### CLINICAL DETAILS

Referral type: \_\_\_\_\_

Referral from: \_\_\_\_\_

Referral from: \_\_\_\_\_

Contrast allergy  No  Yes  
Renal impairment  No  Yes eGFR \_\_\_\_\_  
Pregnant  No  Yes  Unsure  Not Applicable

### REFERRED BY

Contact details: \_\_\_\_\_

Provider number: \_\_\_\_\_

Send copy to: \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Your doctor has recommended you attend Qscan Radiology Clinics.  
You may choose another provider but please discuss this with your doctor first.

**IMAGES**  Online  CD  Return with patient

**REPORT**  Electronic download  Fax