



**BOOK AN
APPOINTMENT**



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OR upload securely to our website: qscan.com.au/bookings

General Referral

PATIENT DETAILS

Patient name: _____

Birth date: _____

Address: _____

Phone: _____ Mobile: _____

EXAMINATION REQUESTED

**Referring for consultation and management of patient with
osteoarthritis, and for consideration of EUFLEXXA**

CLINICAL DETAILS

Contrast allergy ☐ No ☐ Yes

Renal impairment ☐ No ☐ Yes eGFR _____

Pregnant ☐ No ☐ Yes ☐ Unsure ☐ Not Applicable

REFERRED BY

Name: _____

Address: _____

Phone: _____

Fax: _____

Provider number: _____

Signature: _____

Date: _____

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Your doctor has recommended you attend Qscan Radiology Clinics. You may choose another provider but please discuss this with your doctor first.
THANK YOU FOR CHOOSING QSCAN RADIOLOGY CLINICS.



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EXAMINATION REQUESTED

CT guided EUFLEXXA injection

CLINICAL DETAILS

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Renal impairment ☐ No ☐ Yes eGFR _____

Pregnant ☐ No ☐ Yes ☐ Unsure ☐ Not Applicable

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