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☐ MR ☐ MISS
☐ MRS ☐ MS
☐ DR ☐

SURNAME

FIRST NAME

DATE OF BIRTH

ADDRESS

TELEPHONE

Res:

Mob:

ACC #

NHI #

☐ GENERAL X-RAY

MAMMOGRAPHY
☐ SCREENING
☐ DIAGNOSTIC
☐ BIOPSY
☐ HOOK WIRE
☐ OTHER

☐ BONE DENSITOMETRY

ULTRASOUND
☐ OBSTETRIC
☐ NECK
☐ U/ABDO
☐ PELVIS
☐ RENAL
☐ OTHER

VASCULAR ULTRASOUND
☐ DVT
☐ CAROTID
☐ OTHER (specify)

M/SKELETAL ULTRASOUND
☐ SHOULDER
☐ OTHER (specify)

CT
☐ NECK ☐ HEAD
☐ CHEST ☐ SINUSES
☐ UPPER ABDO ☐ RENAL COLIC
☐ PELVIS
☐ M/SKELETAL (specify)

FLUOROSCOPY
☐ J/ASP ☐ HSG
☐ BARIUM ☐ OTHER

MRI
☐ HEAD ☐ SPINE
☐ M/SKELETAL ☐ ARTHROGRAM
☐ OTHER

SCINTIGRAPHY
☐ BONE
☐ OTHER

INTERVENTIONAL
☐ BIOPSY
☐ OTHER

CLINICAL DETAILS

REFERRING PRACTITIONER

TELEPHONE

ARG stores all images electronically

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PHONE REPORT TO
#

FAX REPORT TO
#

SIGNATURE

DATE

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☐ TESTSAFE