Request / Referral for Medical Imaging

Patient Details (*These sections **MUST** be completed)

Patient Code/U.R. Number:

Name*: DOB*:

Address*:

Postcode:

Telephone*: Mobile:

Medicare card*: Concession card:

Exam Requested

- ☐ X-Ray
- ☐ CT
- ☐ MRI
- ☐ Ultrasound
- ☐ Interventional Procedure
- ☐ Nuclear Medicine
- ☐ PET/CT
- ☐ Mammography
- ☐ DEXA/BMD
- ☐ Angiography/DSA
- ☐ Echocardiogram
- ☐ Fluoroscopy/Barium
- ☐ Dental
- ☐ Other: _____

Medical, Surgical & Medical Imaging History

Reason for Referral & Clinical Question

☐ Allergies (list):

☐ Workers Compensation ☐ Urgent appointment

If Renal Function Impaired, recent Creatinine level / eGFR:

All reports and images are available electronically. Please tick for any additional requirements:

☐ Urgent results ☐ Fax ☐ Download to PMS ☐ Phone ☐ Film Report needed by:

Copy Reports to: ☐ Do not send to MyHealth Record

Referrer Details (*These sections **MUST** be completed)

Provider Number*:

Referrer Name*: Specialty:

Address*:

Postcode: Telephone*:

Signature*: Date*: / / Facsimile:

We are bound by the Privacy Act 1988 (Cth) and other state and territory laws that regulate personal information and health information. Details on what information we collect, use, store and disclose and your rights to access and update that information is contained in the Lumus Imaging Privacy Policy. I hereby consent to the collecting, using, storing and disclosing of my personal information and health information in accordance with the Privacy Policy. Your doctor has recommended you use Lumus Imaging. This request is valid at other Radiology providers.

We are predominantly a Bulk Billing service but in some instances a gap payment may apply. Medicare eligibility criteria can change as per mbsonline.gov.au.