holistic imaging

# INTERVENTIONAL RADIOLOGY REFERRAL

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## PATIENT DETAILS

NAME:

DOB:

PHONE:

ADDRESS:

MEDICARE NO:

REF:

HEALTH FUND:

NO:

REQUESTED PROCEDURE (INCLUDE SITE):

CLINICAL NOTES:

| | | | |
|---|---|---|---|
| Known contrast allergy? | Y ☐ | N ☐ | |
| Is the patient pregnant? | Y ☐ | N ☐ | Gestation: |
| Is the patient taking anticoagulants? | Y ☐ | N ☐ | Details: |
| Is the patient taking metformin? | Y ☐ | N ☐ | |

## REFERRER DETAILS (PLEASE PRINT CLEARLY):

NAME OF REFERRING DOCTOR:

CONTACT NUMBER:

PROVIDER NUMBER:

DATE:

SIGNATURE OF REFERRER:

ABN: 63 639 739 398