ANGLESEA SPECIALISTS

Knox Street, PO Box 228, Hamilton, New Zealand
Phone: (07) 957 6086, Fax: (07) 957 6081

Appointment:

Time	Day	Date

Please Circle Mr / Mrs / Ms / Miss / Dr	SURNAME	FIRST NAMES
ADDRESS		DATE OF BIRTH / /
		NHI NUMBER
		ACC NUMBER
TELEPHONE (HM)	TELEPHONE (BUS)	MOBILE

ULTRASOUND

- ☐ Echocardiogram
- ☐ Carotid Doppler
- ☐ Leg Doppler
- ☐ Arterial L R
- ☐ Venous L R
- ☐ DVT
- ☐ Pelvis
- ☐ Renal
- ☐ Abdomen
- ☐ Testes
- ☐ Thyroid
- ☐ Musculo-Skeletal
- ☐ Scintigraphy (Please Specify) _____
- ☐ Bone Density

REFERRER

SIGNATURE

DATE

COPY OF REPORT TO

CLINICAL DETAILS

LMP_____

EXAMINATION

MRT/SONO	NO OF FILM