River RADIOLOGY
Patient Focussed - Problem Oriented

Cone Beam CT Referral Form

1. CT

Upper Limb

☐ Upper Arm ☐ Wrist

☐ Elbow ☐ Hand

☐ Forearm

Lower Limb

☐ Thigh ☐ Ankle

☐ Knee ☐ Foot

☐ Lower Leg

Arthrogram

☐ Arthrogram Upper Limb ☐ Arthrogram Lower Limb

Head/Neck

☐ Orbits ☐ Sinuses

☐ Temporal Bones ☐ Both TMJ

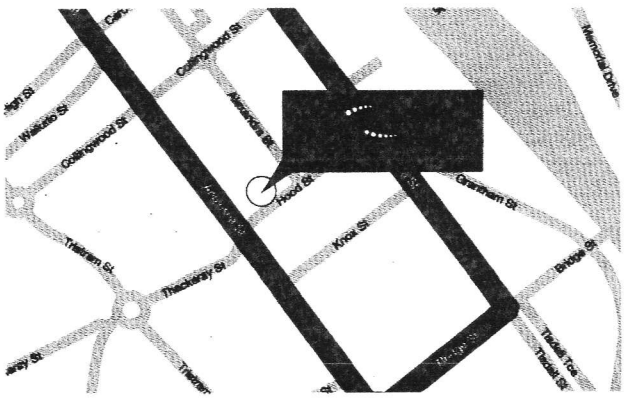
☐ Coronal Jaw ☐ Conventional OPG

☐ Derived Lateral Cephalometric

☐ True Lateral Cephalometric

☐ Entire Oral and Maxillofacial region

☐ Cervical Spine ☐ Other



2. Patient Information

Name

Address

Suburb Date of Birth

Phone Mobile

NHI# ACC#

INS#

3. Referrer Information

Name

Phone

Signature Date

4. Clinical Indication

Notes

P: (07) 839 1800 F: (07) 839 1810

A: **Hood St Clinic**, 30 Hood St, Hamilton 3204

Please return by fax and an appointment will be arranged or call us direct.

◯ **River Radiology Hood St Clinic**