Waikato District Health Board
HEALTH WAIKATO DIVISION

RADIOLOGY

Appointment		Card	No.	W.225D
Date	Time	Packet		

WAIKATO	TAUMARUNUI	TE KUITI	THAMES	TOKOROA

Rado Label

Please print in BLOCK LETTERS

M ☐
F ☐

SURNAME
FIRST NAMES
A.K.A.
ADDRESS

Log in date:

Log in time:

D.O.B.
CONTACT PHONE NO. **CONSULTANT**

Copy of report to:
Doctor

Address

35x43

18x43

DOCTORS NAME (PRINT)	SIGNATURE

Date	Position Held	Clinician Code	Pager

CONTRAST
Type:
Time:
Vol:
Used: Opened:

30x40

24x30

15x30

Is this an ACC case? Yes ☐ No ☐	ACC NO.	Date LMP	Allergies

18x24

Other

Examination

☐ X-Ray
☐ N/Med
☐ VAS
☐ U/S
☐ CT
☐ MRI

EXAMINATION

CLINICAL SUMMARY

Transport
Walking
Chair
Trolley
Bed
Portable

Disabilities
Visual
Aural
Mobility
Language
Intellectual

Examination Consent
Oral ☐
Written ☐
None ☐

Radiographers Name (BLOCK LETTERS)	Checked by:	Radiologist

Case start

Case finish

Screening

Comments see over