



Date _____

Request for imaging

Time _____

APPOINTMENTS AND ENQUIRIES 03 5224 3000

DENTAL REFERRAL

PATIENT DETAILS

Name _____ Phone _____
 _____ Medicare _____
 Address _____ D.O.B _____
 _____ Sex _____
 _____ **Pregnant** Y / N

REFERRAL / REQUESTS FOR

OPG

- Trauma, Infection, Congenital, Surgical, Tumors
- Ceph/Lat
- Impacted Teeth, Periodontal, Caries
- Ceph/PA
- Missing, Crowded, Abnormal Teeth
- Bone Age
- TMJ Arthrosis or Dysfunction
- Routine TMJ

CT DENTAL SCAN

- Maxilla
- Mandible
- Both
- Include sinuses

CLINICAL DETAILS

REPORT

- Return with patient
- Phone #
- Fax #
- Electronic

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38

REFERRER DETAILS

Provider # _____

IMAGES

- Visage
- Film
- CD

Signature _____

Date _____

Copies to _____

RADIUS OFFICE USE ONLY

- Patient name checked
- Patient date of birth checked
- Patient address checked
- Pregnancy status checked
- Correct side and exam checked
- Exam protocolled / approved

- URGENT report**
- Print films
- Phone report

Checked by

Date

APPOINTMENT PREPARATION

Your preparation for your appointment is important. Any specific requirements will be discussed when making your appointment.

IMAGING PROVIDER

Your doctor has recommended that you use Radius Imaging, you may choose another provider but please discuss this with your doctor first.



RADIUS IMAGING

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CAR PARKING

Free parking is available to Radius patients in the on-site car park.

SERVICES



MRI

+



CT Scan

+



Ultrasound

+



Digital X-Ray

+



Dental Scans

+



Interventional
Procedures