Hamilton Radiology

Anglesea Imaging Centre
11 Thackeray Street, Hamilton

Anglesea Women's Health
11 Thackeray Street, Hamilton

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Office use only

PLEASE PHONE FOR AN APPOINTMENT. A CHARGE WILL APPLY FOR ALL EXAMINATIONS.

APPOINTMENT **TIME:** **DAY:** **DATE:**

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

X-RAYS

Pregnant ☐ Yes ☐ No ☐ Unsure

Referrer

Signature Date

ULTRASOUND

- ☐ Pregnancy
- ☐ Abdomen
- ☐ Renal
- ☐ Pelvis
- ☐ Thyroid
- ☐ Breast ☐ L ☐ R
- ☐ Testes
- ☐ Carotid Doppler
- ☐ Musculo-Skeletal
- ☐ Leg Doppler
- ☐ Arterial ☐ L ☐ R
- ☐ Venous ☐ L ☐ R
- ☐ Leg DVT
- ☐ Echocardiography
- ☐ FNA
- ☐ Core Biopsy

CT SCANNING

- ☐ Brain
- ☐ IAM's/Temporal Bones
- ☐ Sinuses
- ☐ Neck
- ☐ Chest
- ☐ Abdomen/Pelvis
- ☐ Renal Colic
- ☐ Vascular Incl. AAA
- ☐ Other Regions
- ☐ High Resolution Chest
- ☐ Cardiac Angiogram
- ☐ Colonography
- ☐ ____________________

MAMMOGRAPHY

- ☐ Bilateral Mammogram
- ☐ Unilateral Mammogram
- ☐ Implants
- ☐ Stereotactic Biopsy
- ☐ Localisation
- ☐ Ductogram

Copy of reports to

Clinical details are required for all referrals.

Maternity Indication Code ____________________

Previous Scan Y/N

LMP ____________________

GRAVIDA ____________________

EDD from Scan ____________________

PLEASE BRING ANY PREVIOUS X-RAYS OR SCANS