HAMILTON RADIOLOGY
MEDICAL IMAGING SPECIALISTS

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ANGLESEA
WOMEN'S HEALTH
Breastcare Centre

MIDLAND
PET-CT

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

EMAIL ADDRESS

ACC NUMBER /NHI

X-RAYS

Pregnant ☐ Yes ☐ No ☐ Unsure

Referring Doctor

Signature Date

ULTRASOUND

- ☐ Pregnancy
- ☐ Abdomen
- ☐ Renal
- ☐ Pelvis
- ☐ Thyroid
- ☐ Breast ☐ L ☐ R
- ☐ Testes
- ☐ Carotid Doppler
- ☐ Musculo-Skeletal
- ☐ Leg Doppler
- ☐ Arterial ☐ L ☐ R
- ☐ Venous ☐ L ☐
- ☐ 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

PET CT

- ☐ 18F-FDG
- ☐ 18F-NAF Bone
- ☐ 18F-PSMA Prostate

- ☐ Brain
- ☐ Vertex - Thighs
- ☐ Whole Body
- ☐ Other eg: lumbar

Copy of reports to

Clinical details are required for all referrals.

_____

Previous Scan Y/N

LMP _____

GRAVIDA _____

EDD from Scan _____