Patient Referral Form

◯ Mr ◯ Mrs ◯ Dr ◯ Miss ◯ Ms **First name** **Surname**

Address

Email

Date of birth **Phone** (Mobile) **Phone** (Home)

NHI# **Is the patient eligible for health benefit?** ◯ Yes ◯ No

ACC# **Are they pregnant?** ◯ Yes ◯ No

Insurer# **Are they diabetic?** ◯ Yes ◯ No

X-ray
◯ General

Ultrasound (US)
◯ Ultrasound Guided Injections

CT
◯ Head
◯ Sinuses
◯ Neck
◯ Chest
◯ Abdomen
◯ Pelvis
◯ Spine
◯ Angiogram
◯ M/Skeletal
◯ Other (specify in notes)

MRI
◯ Head
◯ Spine
◯ Chest
◯ Abdomen
◯ Breast
◯ Pelvis
◯ M/Skeletal
◯ MR Angiogram
◯ MR Arthrogram
◯ MRCP
◯ Other (specify in notes)

Region of interest

Clinical details

Results **Date**

Send report ◯ EDI ◯ Mail **Report priority** ◯ Urgent ◯ Routine

◯ **Phone me** (Mobile)

◯ **Send email notification when patient is booked**

Referring practitioner

Copy report to

Dear Referrer,
All our imaging is digital and available to view direct from your premises.
If you are not set up for access please **Email:** pacs@affinityimaging.co.nz

Signature