

BULK BILLING*

PATIENT DETAILS

Date: _____

Name: _____

DOB: _____ Phone: _____

Address: _____

Medicare No: _____ Exp: _____

EXAMINATION REQUIRED

CLINICAL NOTES

For IV contrast, recent Creatinine level eGFR

COPY REPORT TO:

REFERRER DETAILS

Name: _____ Date: _____

Provider No: _____

Address: _____

Phone: _____

Signature: _____

Now owner operated by local sub-specialty Radiologists

REFERRAL
REFERRAL
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REFERRAL
REFERRAL

WARNERS BAY

9/472 The Esplanade, Warners Bay NSW 2282



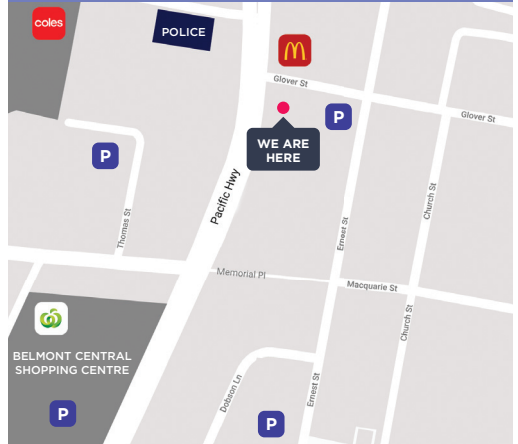
Opening Hours:

Mon-Fri: 8am-5pm Sat: 9am-12noon

Fax: 4915 7476

BELMONT

545 Pacific Highway, Belmont NSW 2280



Opening Hours:

Mon-Fri: 8am-5pm Sat: 9am-12noon

Fax: 4945 0718

YOUR APPOINTMENT DETAILS

Time: _____ Date: _____

Preparation: _____

OUR SERVICES

	Belmont	Warners Bay
X-ray	●	●
Ultrasound	●	●
CT	●	●
Bone Density	●	
OPG/Dental	●	●
Guided US Injections	●	●
Guided CT Injections	●	●
Biopsies	●	●

***All eligible Medicare services BULK BILLED**