

PATIENT DETAILS

Date: _____

Name: _____

DOB: _____ Phone: _____

Address: _____

Medicare No: _____ Exp: _____

MRI EXAMINATION(S) *Each service is limited to 3 per year. Frequency restrictions are rolling, not based on calendar or financial year.*
OVER 16 YEARS - ADULT MRI

- | | |
|--|--|
| <input type="checkbox"/> Brain | <input type="checkbox"/> Chronic Headache with suspected intracranial pathology |
| | <input type="checkbox"/> Unexplained Seizure(s) |
| <input type="checkbox"/> Knee
< 50 yrs | <input type="checkbox"/> Suspected ACL tear following acute trauma |
| | <input type="checkbox"/> Suspected meniscal tear following acute trauma and inability to extend knee |
| <input type="checkbox"/> Cervical Spine | <input type="checkbox"/> Radiculopathy |
| | <input type="checkbox"/> Trauma |

UNDER 16 YEARS - PAEDIATRIC MRI

- | | |
|---|--|
| <input type="checkbox"/> Brain (Headaches, Seizures) | |
| <input type="checkbox"/> Knee (Internal Derangement) | |
| <input type="checkbox"/> Hip | <input type="checkbox"/> Septic Arthritis* <input type="checkbox"/> Perthes*
<input type="checkbox"/> Slipped Epiphysis* |
| <input type="checkbox"/> Wrist (Scaphoid fracture)* | |
| <input type="checkbox"/> Elbow (Fracture)* | |
| <input type="checkbox"/> Spine | <input type="checkbox"/> Cervical* <input type="checkbox"/> Lumbosacral*
<input type="checkbox"/> Thoracic* <input type="checkbox"/> Pain* <input type="checkbox"/> Trauma* |

**For Medicare eligibility, prior radiographic examination is required.*
☐ **OTHER MRI** (non-rebatable); _____

CLINICAL NOTES
COPY REPORT TO
REFERRING DOCTOR

Name: _____

Date: _____

Provider No: _____

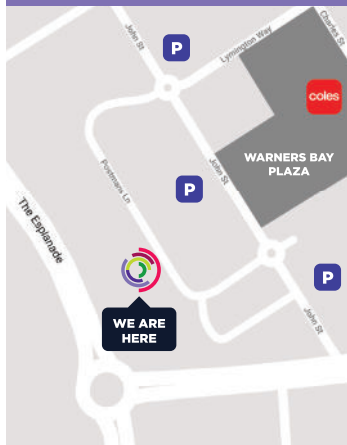
Phone: _____

Address: _____

Signature: _____

WARNERS BAY

9/472 The Esplanade,
Warners Bay NSW 2282
Fax: 4915 7476



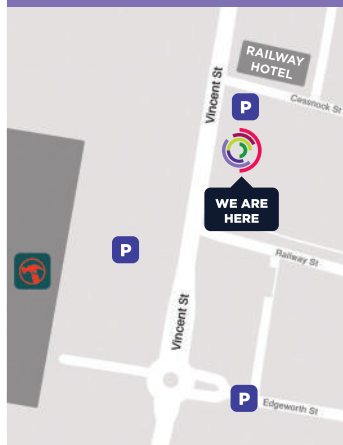
BELMONT

545 Pacific Highway,
Belmont NSW 2280
Fax: 4945 0718



CESSNOCK

1 Cessnock Street,
Cessnock NSW 2325
Fax: 4013 5088



YOUR APPOINTMENT DETAILS

Time: _____ Date: _____

Preparation: _____

OUR SERVICES

	Warners Bay	Belmont	Cessnock
MRI			●
X-ray	●	●	●
Ultrasound	●	●	●
CT (Including Angiogram)	●	●	●
CT Colonography			●
CT Calcium Score		●	
Bone Density		●	●
OPG/Dental	●	●	●
Guided US Injections	●	●	●
Guided CT Injections	●	●	●
Biopsies	●	●	●