

Mr Mrs Dr Miss Ms | First name: _____ | Surname: _____

Address: _____

Email: _____

Date of birth: / / | Tel (Hm): _____ | Tel (Mob): _____

NHI#: _____ | ACC#: _____ | Insurer #: _____ | Is patient diabetic? Yes No

Region of interest: _____

Clinical details: _____

Results: _____ Date: _____ Follow-up appointment date: _____

Send report: EDI Fax Mail | Report priority: Urgent Routine

Phone me **Mobile Ph:** _____

Send email notification when patient is booked **Email address:** _____

Referring practitioner: _____

Copy of report to: _____

All our imaging is digital and available to view direct from your premises. If you are not set up for access or require hard copies please contact us: **Ph: 09 630 3324, Email: pacs@radiology.co.nz**



X-ray

- General
- Fluoroscopy

Ultrasound (US)

- Pregnancy
- Upper abdomen
- Pelvis
- Renal
- M/Skeletal
- Other (specify in notes)

CT

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

MRI

- M/Skeletal
- MR Arthrogram
- Brain
- Head & Neck
- Breast
- Liver/MRCP
- Abdomen
- Enterography
- Spine
- Prostate
- MR Angiogram
- Other (specify in notes)

Nuclear imaging

- Bone scan – SPECT-CT
- Sentinel node scan
- Thyroid scan
- Parathyroid
- Renogram – DTPA
- Renogram – DMSA
- Colonic transit
- Hepatobiliary
- Gastric emptying
- Other (specify in notes)

Renal function (for contrast studies)

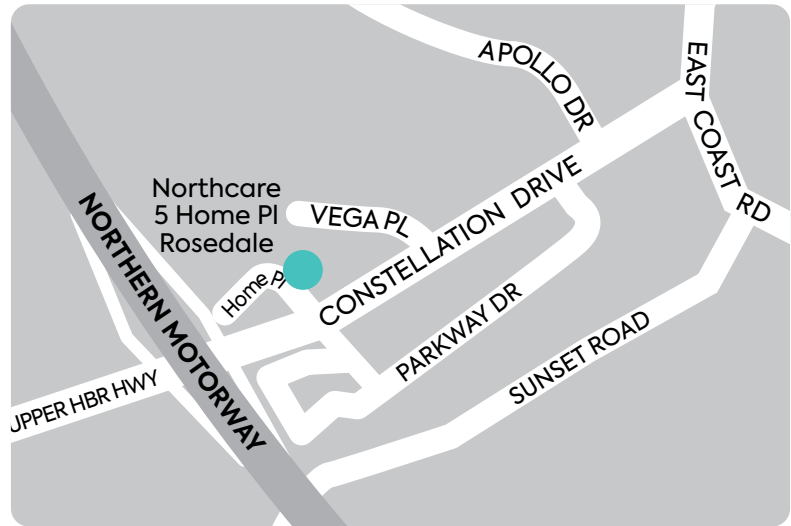
Creatinine: _____

eGfr: _____

(values must be less than 3 months)



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E bookings@northmri.co.nz



**North MRI and Mercy Radiology
entrance is to the right of the
main Northcare entrance**

