CoreVue RADIOLOGY

REFERRAL FORM

Patient Name: **Date of Birth:**

Address: **Sex:** ☐ **M** ☐ **F**

Medicare No: **Telephone:**

☐ X-Ray ☐ Ultrasound ☐ Mammography ☐ CT

☐ MRI ☐ Bone Densitometry ☐ Body Composition Analysis ☐ Procedure

PROCEDURE & CLINICAL NOTES:

MRI:

☐ **Y** ☐ **N** History of Metalwork, Grinding, Welding?

☐ **Y** ☐ **N** Cardiac Pacemaker?

☐ **Y** ☐ **N** Implanted Electronic Device?

☐ **Y** ☐ **N** Brain Aneurysm Clip?

☐ **Y** ☐ **N** Ear Implant?

☐ **Y** ☐ **N** Eye Metal Fragment?

CT SCAN:

Diabetes on Metformin?

☐ **Yes** ☐ **No**

eGFR or Creatinine:

Date of renal function test:

Referrer:

Signature:

Date:

Copy to:

Our website:
www.corevue.com.au

Phone: 03 9969 0900
Fax: 03 9968 9100

Ground Floor,
115 Cotham Rd,
Kew, VIC 3101