Carlisle health

REQUEST FOR
ELECTRONIC IMAGE TRANSFER

I certify that the studies I am requesting below are required for the ongoing clinical management of the patient indicated. I have obtained the patient's consent to obtain prior imaging.

AUTHORISATION

Name*: Department:*

Phone:* Email:*

Date required to complete imaging transfer by:

PATIENT

First Name*: Last Name:*

Medicare No: DOB*:

IMAGE TRANSFER DETAILS:

Imaging from*: (Company and Site Name)

Imaging to*:

Studies required to transfer* (Modality and Date if known) :

Exact Radiology • Gatton • Plainland • Springfield • Ipswich North • Ipswich South	F: 07 3319 4664 (All)
Exact Express (All)	F: 07 3112 1903
Truescan Radiology	F: 02 9726 2399
Lakes Radiology	F: 02 4973 3823
Dr Glenn and Partners Kogarah	F: 02 9587 7147
Dr Glenn and Partners Rockdale	F: 02 9567 4150
Dr Glenn and Partners Wollongong	F: 02 4243 4099
Radiology Queensland Group • Chapel Hill • Oxley • Inala • Underwood • Sunnybank	F: 07 3319 4664 (All)
Coastal Medical Imaging	F: 07 5413 5050
Bayside Radiology	F: 07 4197 6622
Bolsover Radiology	F: 07 4930 7522
Bundaberg Radiology	F: 07 4150 0222
Beachside Radiology	F: 02 6691 7822
Clearview Medical Imaging	F: 02 8322 4091