



**DARLING DOWNS  
RADIOLOGY**

**APPOINTMENT DETAILS**

Arrival Time \_\_\_\_\_ Date \_\_\_\_\_

**IMPORTANT MEDICARE ADVICE**

Your referrer has recommended you use Darling Downs Radiology. You may choose another provider, but please discuss this with your referrer first.

PLEASE BRING THIS REQUEST FORM AND RELEVANT PREVIOUS FILMS AT TIME OF EXAMINATION

**REFERRAL AND/OR REQUEST(S) TO THE DOCTORS OF DARLING DOWNS RADIOLOGY**

**PATIENT DETAILS**

Name

Address

Medicare

**INVESTIGATIONS REQUIRED**

**CLINICAL NOTES**

**REFERRING DOCTOR DETAILS**

Doctor

Address

Provider No.

Phone No.

**REFERRING DOCTOR SIGNATURE**

(Doctor's Name, Provider Number and Date are a legal requirement)

*Thank you for choosing Darling Downs Radiology*

**COPY OF REPORT TO**

**REFERRAL DATE**



For patients who may require intravenous contrast (CT & MRI) and the patient is over 70 years old, or has suspected or known renal impairment please supply the serum levels within previous:  
• 3 months for stable out-patients • 7 days for stable in-patients.

Creatinine = \_\_\_\_\_ ; 3 GFR = \_\_\_\_\_ Date of test: \_\_\_\_\_



**AVAILABLE SERVICES**

Magnetic Resonance Imaging	Nuclear Medicine	Ultrasound	Dental X-ray	Cardiac CT
Computed Tomography	Mammography	Vascular Ultrasound	Echocardiography	Interventional procedures
CT Angiography	Bone Densitometry	Obstetric Ultrasound	General X-ray	Musculoskeletal imaging

## PATIENT PREPARATION

The following are for adult studies. For children, or for patients who you may feel may not cope with the particular preparation, please contact our staff. For any particular diagnostic or clinical problem, please consult one of our radiologists.

**If you have a history of significant allergic responses, asthma or diabetes, please tell our reception staff when making your appointment. Medication (to reduce the small risk of an allergic reaction), may be required, which can be picked up from our offices. This will be organised on an individual basis.**

### X-RAY EXAMINATIONS

Please discuss at time of booking.

#### MAMMOGRAPHY

Please do not use talcum powder or deodorant on day of the examination. A two piece outfit is preferable.

### ULTRASOUND

**ABDOMEN:** Fast for 6 hours. Please do not smoke during this period. Take normal medications with a sip of water. (Note – no milk or soft drinks please).

**RENAL:** Bladder must be full at appointment time. Drink one litre of clear fluid/cordial finishing 1 hour prior to the appointment time. Do not empty your bladder.

**PELVIS:** Bladder must be full at appointment time. Drink one litre of clear fluid/cordial finishing 1 hour prior to the appointment time. Do not empty your bladder.

**OBSTETRIC ULTRASOUND:** A full bladder will be required. Empty bladder one hour prior to the appointment. Drink 500mls – 1 litre of clear fluid over the next half hour.

**BREAST, THYROID ULTRASOUND, DUPLEX CAROTID, LEG VEINS, PENILE DOPPLER:** No preparation required.

**RENAL ARTERIES, ABDOMINAL AORTA DOPPLER:** Please fast for 12 hours prior to the examination, with no smoking during this time.

### MAGNETIC RESONANCE IMAGING

Please inform our receptionist if you have a pacemaker, aneurysm clip, or inner ear implant, when making your appointment. Any specific preparation instructions will be given at time of booking.

### NUCLEAR MEDICINE – SPECT CT

Please contact Darling Downs Radiology for specific preparation.

### BONE MINERAL DENSITY

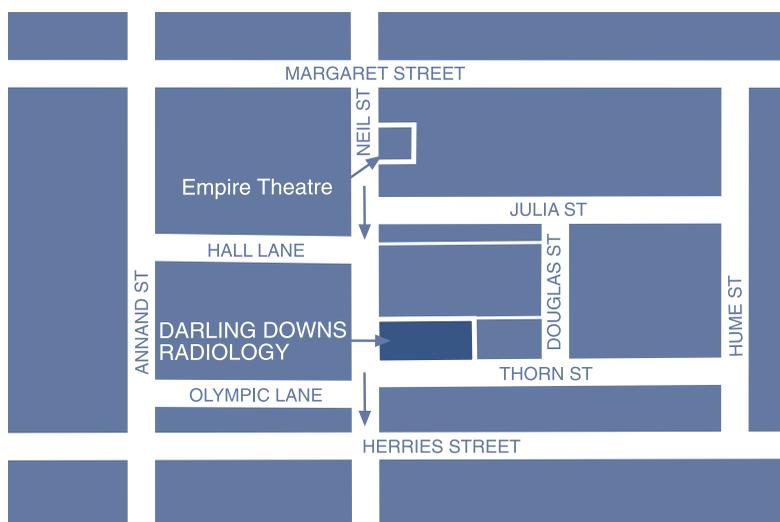
No preparation required. A two piece outfit is preferable.

### C.T. SCANNING

#### ABDOMEN, PELVIS, CHEST, HEAD:

- No food for 2 hours
- Drink 1 glass of water every 15 mins from ..... am/pm  
(approx 1.5 litres) **You may go to the toilet.**

**LUMBAR SPINE, SINUSES:** No preparation is required.



70 Neil Street  
Toowoomba 4350

Ph: (07) 4632 9533  
Fax: (07) 4632 7164

(Free parking available  
at rear of building)

