**Granite Belt**
Diagnostic Imaging

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## Patient Details

Name

Contact Details

Date of Birth

Medicare No

## Examination Requested

## Clinical Details

## Referred By

Contact Details

Provider Number

Office Use Only
Name: ☐
DOB: ☐
Exam: ☐
Side: ☐
Initial:

Signature ______________________ Date __________

**Pregnant** ☐ No ☐ Yes
**Creatinine** ______________________
**eGFR** __________ Date __________

Contrast allergy ☐ No ☐ Yes
Renal compromise ☐ No ☐ Yes
Metformin ☐ No ☐ Yes

Your doctor has requested that you use Granite Belt Diagnostic Imaging.
You may choose another provider, but please discuss this with your doctor

CT
X-Ray
Ultrasound
BMD