KAIPARA ULTRASOUND

197 Rodney St, Wellsford 0900
Phone: 09 973 3164
Email: admin@kaiparaultrasound.co.nz
Web: www.kaiparaultrasound.co.nz

Referral Form

PATIENT DETAILS

☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Master ☐ Dr ☐ Other (tick boxes)

Surname _____ First name _____

Address _____

_____

Phone [ ] _____ Email _____

DOB / / NHI No. _____ ACC No. _____

CLINICAL DETAILS

_____

_____

_____

_____

_____

SCAN REQUIRED (tick boxes)

General:

☐ Upper abdo
☐ Pelvis
☐ Renal
☐ Neck
☐ Foreign body
☐ Soft tissue lump
☐ Other

_____

Musculoskeletal:

☐ Shoulder
☐ Elbow
☐ Wrist
☐ Knee
☐ Ankle
☐ Other

_____

_____

Obstetric:

☐ Dating
☐ Nuchal
☐ Growth
☐ Anatomy
☐ Other

_____

LMP=
EDD=

Vascular:

☐ DVT
☐ Carotid
☐ Other

Other:

_____

_____

_____

_____

REFERRER DETAILS

Name _____ Registration No. _____

Signature _____ Date / /

How would you prefer to receive report: ☐ Fax ☐ EDI ☐ Email

Urgent?: ☐ Yes ☐ No

CC: _____