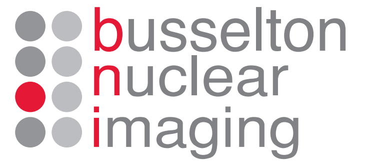
Ph: 08 9754 7450
Fax: 08 9754 7995
115 Bussell Highway
WEST BUSSELTON 6280




## PATIENT DETAILS

- ❑ V.A.
- ❑ W. Comp.
- ❑ Private
- ❑ Hosp. Patient
- ❑ MVIT
- ❑ Pensioner / Health Care Card

Surname: ............................................................................................

Given Name: ............................................................................................

D.O.B.: ................................Medicare:............................................

Address: ............................................................................................

Phone Home: ........................ Work:..................... Mobile:...........................

Concession Card No.: ...........................................................................

## Examination Request:

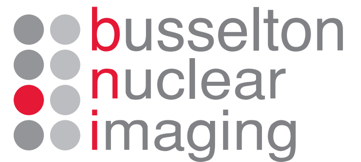
- ❑ Bone Scan
- ❑ Myocardial Perfusion SPECT
  - ❑ Exercise Stress
  - ❑ Persantin
- ❑ HIDA Biliary Scan
- ❑ DTPA Renography
- ❑ DMSA Renal Scan
- ❑ Thyroid Scan
- ❑ Gallium Infection Study
- ❑ Lung Perfusion Scan
- ❑ Gated Heart Pool Scan (GHPS)
- ❑ Sentinel Lymph Node Mapping
- ❑ Other___________________________________________

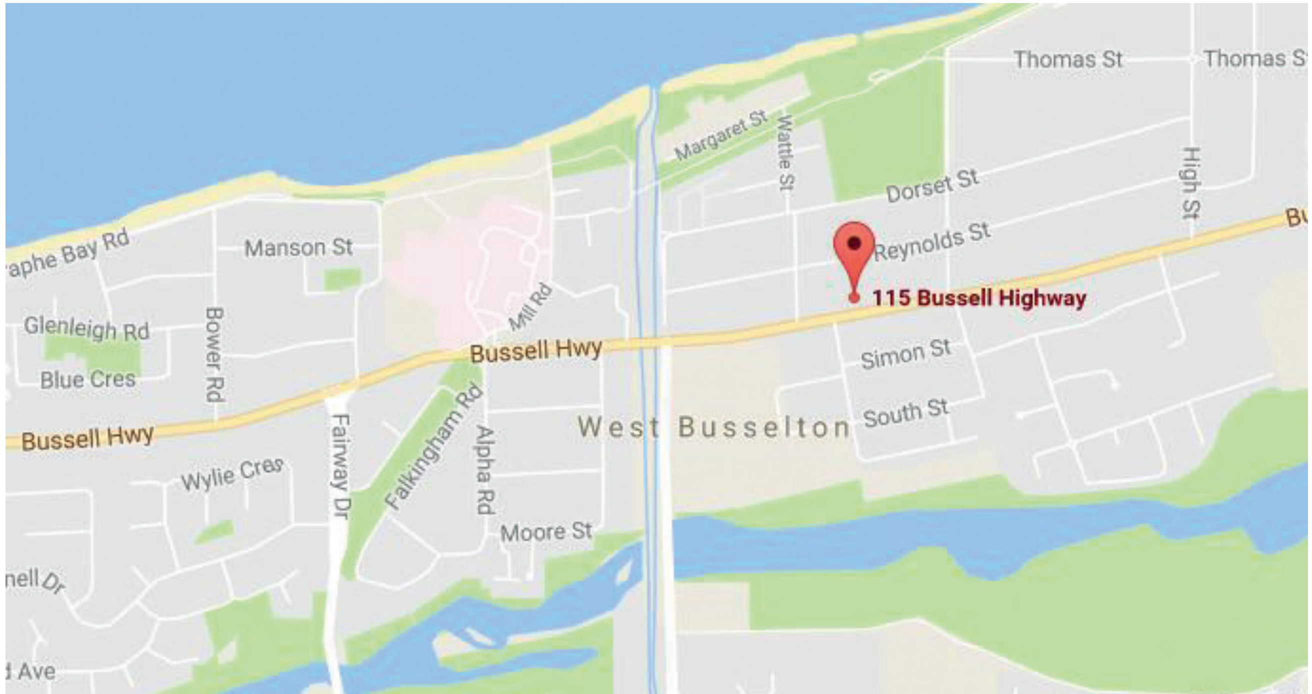
## Clinical History:

*Referring Practitioner Signature:*_______________________________________ *Date:*____/____/____

Ph: 08 9754 7450
Fax: 08 9754 7995
115 Bussell Highway
WEST BUSSELTON 6280

# MAP DIRECTIONS




PRIVACY ACT 1988, Patient Consent

I provide my consent for Busselton Nuclear Imaging to collect, use and disclose my personal information for any account, medical, mangagement and quality assurance purposes.

I understand that I am entitled to access my health records by requesting access in writing to Busselton Nuclear Imaging, but also understand access can be denied where it may create a serious threat to life or health, there is a legal impediment to access, the access would have an unreasonable impact on the privacy of another, the request is frivolous or if the information relates to legal proceedings.

I understand that I may withdraw my consent in writing to Busselton Nuclear Imaging to use and disclose of my personal information (except when legal obligations must be met).

Patient Name:______________________________________________ Date:____/____/____

Signature of Patient or Guardian: **X** ______________________________________________

Witnessed (Staff Member):________________________________ ❑ Patient Previously Signed

Technologist Notes:

A&L PRINTERS — Tel: 9721 1599