RADIOLOGY REQUEST FORM

PATIENT INFORMATION

Member Number:_____ Patient Date of Birth: DD / MM /YYYY Dependant Code: _____Gender: M / F

Patient Name:_____ Patient Surname: _____

Patient Tel No: (W)_____ (H)_____ Cell no:_____

REFERRING GENERAL PRACTITIONER'S INFORMATION

Doctor Name and Surname: _____Practice No:_____

Doctor Tel No:_____ Cell No:_____ Email:_____

LIMBS		
	55100	Pelvis
	56120	Pelvis and Hip
	65100	Hand Left
	65105	Hand Right
	65120	Finger
	65130	Wrist Left
	65135	Wrist Right
	65140	Scaphoid Left
	65145	Scaphoid Right
	64100	Forearm (Radius & Ulna) Left
	64105	Forearm (Radius & Ulna) Right
	63100	Elbow Left
	63105	Elbow Right
	62100	Humerus Left
	62105	Humerus Right
	61130	Shoulder Left
	61135	Shoulder Right
	61120	Acromio-Clavicular joint Left
	61125	Acromio-Clavicular joint Right
	61100	Clavicle Left
	61105	Clavicle Right
	61110	Scapula Left
	61115	Scapula Right
	74120	Foot Left
	74125	Foot Right
	74100	Ankle Left
	74105	Ankle right
	74130	Calcaneus Left
	74135	Calcaneus Right
	73100	Lower Leg Left

LIMBS		
	72120	Left Knee including Patella
	72125	Right Knee including Patella
	73105	Lower Leg Right
	72100	Knee Left
	72105	Knee Right
	72140	Patella Left
	72145	Patella Right
	71100	Femur Left
	71105	Femur Right
	74145	Toe
	56100	Hip Left
	56110	Hip Right
SPINAL COLUMN		
	53110	Lumbar Spine – one or two views
	52100	Thoracic Spine - one or two views
	51110	Cervical Spine - one or two views
CHEST		
	30100	Chest, single view
	30110	Chest PA & Lateral – two views
ABDOMEN		
	40100	Abdomen
	40105	Abdomen supine, erect or decubitus
ULTRASOUND **Only in Pregnancy:** Ultrasound two investigations / pregnancy		
	43250	Study of Pregnant uterus – First Trimester
	43260	Study of Pregnant uterus – Second Trimester
	43273	Study of Pregnant uterus – Third Trimester – Follow-up
ICD 10:		

Clinical Information of x-rays/ultrasounds **not covered** but required:

I certify that the above information is correct and give consent to the x-rays/ultrasounds indicated above. I agree to pay for any tests not covered by Topmed Networks.

Member/Patient Signature: _____

Signature of General Practitioner: _____ Date: _____