Keperra
Diagnostic Imaging

Great Western Super Centre
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Patient Details

Name

Contact Details

Date of Birth

Medicare No

Examination Requested

Clinical Details

Referred By

Contact Details

Provider Number

CT
BMD
X-Ray
OPG/LC
Ultrasound

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

Signature _____ Date _____

Report and films ☐ Fax ☐ Electronic download ☐ Return with patient

Referral pad reorder ☐ A4 (computerised) ☐ A5 (manual)

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