



AUCKLAND RADIOLOGY GROUP

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<input type="checkbox"/> MR <input type="checkbox"/> MISS <input type="checkbox"/> MRS <input type="checkbox"/> MS <input type="checkbox"/> DR <input type="checkbox"/>		SURNAME		FIRST NAME		DATE OF BIRTH					
ADDRESS				TELEPHONE		ACC #					
				Res:							
				Mob:		NHI #					
<input type="checkbox"/> GENERAL X-RAY AND FLUOROSCOPY											
MAMMOGRAPHY <input type="checkbox"/> SCREENING <input type="checkbox"/> DIAGNOSTIC <input type="checkbox"/> BIOPSY <input type="checkbox"/> HOOK WIRE <input type="checkbox"/> OTHER		ULTRASOUND <input type="checkbox"/> OBSTETRIC <input type="checkbox"/> NECK <input type="checkbox"/> U/ABDO <input type="checkbox"/> PELVIS <input type="checkbox"/> RENAL <input type="checkbox"/> OTHER M/SKELETAL ULTRASOUND <input type="checkbox"/> SHOULDER <input type="checkbox"/> OTHER (specify)		VASCULAR ULTRASOUND <input type="checkbox"/> DVT <input type="checkbox"/> CAROTID <input type="checkbox"/> OTHER (specify)		CT <input type="checkbox"/> HEAD <input type="checkbox"/> CHEST <input type="checkbox"/> SINUSES <input type="checkbox"/> UPPER ABD <input type="checkbox"/> MINI SINUSES <input type="checkbox"/> RENAL COLIC <input type="checkbox"/> NECK <input type="checkbox"/> PELVIS <input type="checkbox"/> M/SKELETAL		MRI <input type="checkbox"/> HEAD <input type="checkbox"/> SPINE <input type="checkbox"/> M/SKELETAL <input type="checkbox"/> ARTHROGRAM <input type="checkbox"/> OTHER			
<input type="checkbox"/> BONE DENSITOMETRY						SCINTIGRAPHY <input type="checkbox"/> BONE <input type="checkbox"/> OTHER		INTERVENTIONAL <input type="checkbox"/> BIOPSY <input type="checkbox"/> OTHER			
CLINICAL DETAILS						REFERRING PRACTITIONER					
						TELEPHONE					
DISTRIBUTION		IMAGES		REPORT		PHONE REPORT TO		SIGNATURE		DATE	
REFERRER		<input type="checkbox"/>		<input type="checkbox"/>		#					
PATIENT		<input type="checkbox"/>		<input type="checkbox"/>		FAX REPORT TO		COPY OF REPORT TO			
						#					



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