



AUCKLAND RADIOLOGY GROUP

Dr Barnaby Clark
Dr Brigid Connor
Dr Nicholas Dodd
Dr George Foote
Dr Wendy Hadden
Dr Helen Moore
Dr Vicki Morganti
Dr Kate O'Connor
Dr Clinton Pinto
Dr Robert Sim
Dr Andrew Smith
Dr Neal Stewart
Dr Glen Thomson

Dr Paul White
Dr John Wilson
Dr Steve Wood

Dr Richard Beedie
Dr Anne Blue
Dr Dawn Burkimsher
Dr Steve Kelly
Dr Jane Peart
Dr David Perry
Dr Penny Thomson
Dr Rebecca Woodward

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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"/> NECK <input type="checkbox"/> HEAD <input type="checkbox"/> CHEST <input type="checkbox"/> SINUSES <input type="checkbox"/> UPPER ABDO <input type="checkbox"/> RENAL COLIC <input type="checkbox"/> PELVIS <input type="checkbox"/> M/SKELETAL (specify)		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			
REFERRER		<input type="checkbox"/>		<input type="checkbox"/>		#			
PATIENT		<input type="checkbox"/>		<input type="checkbox"/>		FAX REPORT TO			
						#			
				SIGNATURE		DATE			
				COPY OF REPORT TO					



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