Western Health
MEDICAL IMAGING

FUJI FILM MIX
DIGITAL IMAGE TRANSFER

Date Images Transferred:		**Images Sent By:**	

REQUESTING IMAGES FROM *(Please tick)*			
WESTERN HEALTH		PMCC (PETERMAC)	
ROYAL MELBOURNE		ROYAL DARWIN (NT)	
ROYAL CHILDRENS		ROYAL WOMENS	
ALFRED HOSPITAL		ST. VINCENTS HOSPITAL	
AUSTIN HOSPITAL		TASMANIA HEALTH	
BALLARAT HOSPITAL		***PRIVATE***	
BARWON (GEELONG)		CAPITAL RADIOLOGY	
BENDIGO HOSPITAL		DIAGNOSTIC CARE	
BREAST SCREEN		EPWORTH MEDICAL IMAGING	
CABRINI HOSPITAL		FUTURE MEDICAL IMAGING GROUP (FMIG)	
EASTERN (BOXHILL)		GOULBURN VALLEY HEALTH	
EPWORTH HOSPITAL		I-MED	
MONASH (SOUTHERN)		LAKE IMAGING	
NORTHERN (EPPING)		RADIOLOGY IMAGING SOLUTIONS (RIS)	
PENINSULA (FRANKSTON)		WESTERN PRIVATE (PET CENTRE)	

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PATIENT DETAILS: *(Please **PRINT clearly** OR **stick patient bradma** below)*	
UR Number:	
Full Name:	
DOB:	
Address:	

WH HUB AND SPOKE NUMBERS		
BUSINESS HOURS [08:00-17:00]		
FH / SH/ JKWC	FAX: 8345 6325	PH:8345 6234
AFTER HOURS *(please also call radiographers if faxing)*		
FOOTSCRAY	FAX: 8345 7066	PH: 8345 6680
SUNSHINE/JKWC	FAX: 8345 1736	PH: 9055 3124

CLINICAL REASON FOR TRANSFER:						
STUDY DATE:						
MODALITY/STUDY:						
NO# OF IMAGES: (SENDING HOSPITAL TO COMPLETE)						
REPORT TO BE FAXED:	***YES: 8345 6325***					
REQUESTING CLINICIAN DETAILS:						
CLINICIAN NAME:						
CONTACT NUMBER:						
SIGNATURE:						