

Statement of Confirmation - Reciprocal Health Card Referral

To: **North Queensland X-Ray Services**

Please fax to the relevant clinic together with your referral or send direct with your patient.

Fax Number

Cairns Practice:	126 Mulgrave Road	07 4041 3211
Smithfield Practice:	Campus Shopping Village	07 4057 5800
Townsville Practice:	252 Ross River Road	07 4779 3711
Aitkenvale Practice:	295 Ross River Road	07 4728 9238
Cranbrook Practice:	531 Ross River Road	07 4723 2260
Ayr Practice:	Shop 2/186 Queen Street	07 4783 4777

Date: _____

Re: Referral for Reciprocal Health Care Card Holder

Name of Patient: _____

Date of Birth: _____

I confirm that the x-ray / ultrasound / CT examination requested by me for this patient was deemed urgent and necessary at consultation. (please circle the relevant procedure)

Doctor's Signature: _____

Doctor's Stamp:

This statement is to accompany your referral for any patient who holds a Reciprocal Health Care Card as issued by Medicare Australia.



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