

San Radiology & Nuclear Medicine

EOS® EDGE (Long Length Low Dose Imaging) Request

Make an
appointment



SYDNEY ADVENTIST HOSPITAL

185 Fox Valley Rd
Wahroonga NSW 2076

Radiology

Level 3, Tulloch Building

E: radiologybookings@sah.org.au

P: 9480 9850

Patient Name: _____

D.O.B: _____

Address: _____

Postcode: _____

Phone: _____ Mobile: _____

MRN: _____

EOS IMAGING REQUIREMENTS - BULK BILLED

- | | | | | |
|---|------------------------------|-------------------------------|--|--|
| <input type="checkbox"/> Full spine | <input type="checkbox"/> AP | <input type="checkbox"/> LAT | | |
| <input type="checkbox"/> Full Spine including lower limbs | <input type="checkbox"/> AP | <input type="checkbox"/> LAT | | |
| <input type="checkbox"/> Full Spine and pelvis | <input type="checkbox"/> AP | <input type="checkbox"/> LAT | | |
| <input type="checkbox"/> Lower limb/s | <input type="checkbox"/> AP | <input type="checkbox"/> LAT | | |
| <input type="checkbox"/> Cervical spine only | <input type="checkbox"/> AP | <input type="checkbox"/> LAT | <input type="checkbox"/> Flexion & Extension | |
| <input type="checkbox"/> Thoracic spine only | <input type="checkbox"/> AP | <input type="checkbox"/> LAT | <input type="checkbox"/> Flexion & Extension | <input type="checkbox"/> Lateral Bending |
| <input type="checkbox"/> Lumbar spine (including pelvis) | <input type="checkbox"/> AP | <input type="checkbox"/> LAT | <input type="checkbox"/> Flexion & Extension | <input type="checkbox"/> Lateral Bending |
| <input type="checkbox"/> Pre Op Imaging | | | | |
| <input type="checkbox"/> Mako | <input type="checkbox"/> Hip | <input type="checkbox"/> Knee | R / L / BIL (Please Circle) | |
| <input type="checkbox"/> Other (Please Specify) _____ | | | | |

ASSESSMENT REQUIREMENTS (POST-PROCESSING)

- ☐ Postural Assessment
- ☐ Leg Lengths
- ☐ Other Measurements (Please Specify) _____

OTHER IMAGING

- ☐ CT (Low Dose) _____
- ☐ MRI (3T) _____
- ☐ US _____
- ☐ Other _____



CLINICAL NOTES (Specific regions of interest/pain can be marked on the EOS images provided above)

REFERRER DETAILS

☐ Specialist ☐ GP ☐ Podiatrist ☐ Chiro ☐ Osteo ☐ Physio

Name: _____

Provider No: _____

Address: _____

Copy to: _____

Phone: _____ Fax: _____

Signature: _____ Date: _____

Your doctor has recommended you use San Radiology and Nuclear Medicine.
You may choose another provider but please discuss this with your doctor first

PATIENT INFORMATION

For a quicker check in, please email, fax or scan the QR code to send this request ahead of your appointment.
Please bring this request and any relevant previous imaging with other providers to your appointment.

MY APPOINTMENT DETAILS

Appt Date: _____ Appt Time: _____

Note: _____

HOW TO FIND US

San Radiology: Enter the Hospital entrance at the traffic lights on Fox Valley Road (Entry 1). Park in

