



Geelong Medical Imaging – Referrer Registration

- ☐ I wish to register as a new provider for patient referral to GMI; and/or
- ☐ I request access to the online PACS system for the purpose of viewing imaging studies and reports of patients I am treating.

I understand that my access to and use of the PACS imaging system is subject to the terms and conditions of use as set out by GMI. I understand that use of the system is audited, and monitored, and that all use must be consistent with the provisions of the Health Records Act (Vic) 2001, and the GMI Privacy Policy.

| | | |
|---------------------------------------|---|----------------|
| First name: | Surname: | Prefix: |
| Specialty: | Provider No.: | |
| Clinic Name: | | |
| Address: | | |
| Phone: | Fax: | |
| Email: | | |
| Operating system: | <input type="checkbox"/> Windows <input type="checkbox"/> MAC | |
| Report delivery via: | <input type="checkbox"/> HealthLink <input type="checkbox"/> ReferralNet <input type="checkbox"/> Fax <input type="checkbox"/> Mail | |
| Referral stationary: | <input type="checkbox"/> A4 Computer Letterhead <input type="checkbox"/> A5 Pads | |
| Are you currently a registrar? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Signature _____ Date _____

Please forward completed form by fax to 52494656 or email to admin@gmi.net.au

Your username and password will be forwarded to the email address specified above.