NUCLEAR MEDICINE/BONE MINERAL DENSITY

Central Health

Medical Imaging

Date Received by MI Dept.

REQUEST FOR EXAM & CONSULTATION

INCOMPLETE OR ILLEGIBLE REQUISITIONS WILL BE RETURNED

1 EXAM REQUIRED: _____

2 PATIENT INFORMATION:

Status: ☐ OUTPATIENT ☐ INPATIENT
☐ MCP ☐ WHSCC ☐ NR ☐ DVA ☐ DND
☐ OTHER

Name: _____

Address: _____

_____

City: _____ Postal Code: _____

DOB: _____ Sex: _____

Phone: _____ (Work): _____

MCP #: _____ Chart #: _____

3 Please identify urgency:

Priority Circle appropriate number:	**Specific Date?** D/M/Y
1 Urgent (0-14 days)	
2 Non-Urgent (0-30 days)	
3 Follow-up (Date MUST be Specified)	
4 Screening	

4 To be completed by Medical Imaging:

Appointment date: _____

Patient Notified: ☐ Phone ☐ Message ☐ Mail

Patient preparation instructions: ☐ Yes ☐ No

Exam protocol:

5 CLINICAL INFORMATION:

Did the patient have a previous Barium study? ☐ Yes ☐ No

If Yes, when? _____

Patient's Weight: _____

Does patient have any contact precautions? ☐ Yes ☐ No

Has the patient received IV contrast in past 2 month? ☐ Yes ☐ No

Does patient have any allergies? ☐ Yes ☐ No

Is patient breastfeeding? ☐ Yes ☐ No

Patient's LMP : _____

List any medications the patient is taking:

_____

_____

Describe any allergies and reactions: _____

_____

6 CLINICAL INDICATIONS FOR EXAM (including previous relevant studies): _____

_____

_____

_____

_____

CLINICAL DIAGNOSIS: _____

_____

_____

7 Requesting Physician (PRINT & SIGN): _____

Date: _____ **Phone Number:** _____

Report to be sent to Dr. (PLEASE PRINT): _____

Adapted from Eastern Health, January 2008.
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