Central Health

X-RAY

Date Received by MI Dept.

REQUEST FOR EXAM & CONSULTATION

Medical Imaging

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	
4 Screening	

4 To be completed by Medical Imaging:

Appointment date: _____

Patient Notified: ☐ Phone ☐ Message ☐ Mail

Patient preparation instructions: ☐ Yes ☐ No

Exam protocol:

IV Contrast: ☐ Yes ☐ No

Sedation: ☐ Yes ☐ No

5 CLINICAL INFORMATION:

Is patient on Warfarin, ASA or other anticoagulant? ☐ Yes ☐ No

Is patient receiving Metformin or Glucophage? ☐ Yes ☐ No

Has patient received IV contrast before? ☐ Yes ☐ No

Has patient had an adverse reaction to IV contrast? ☐ Yes ☐ No

Does patient have any contact precautions? ☐ 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.
FRM – DIS019