



fraserhealth

MEDICAL IMAGING REQUISITION

DIXX102601C

Rev: Apr 05/16

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Hospital Site:	Surname	First Name	Sex M F
Appt. Date: Time:	Address		
<input type="checkbox"/> Not Willing to be booked at alternate hospital <input type="checkbox"/> Interpreter Needed? Language _____	City	Home Phone	
	Date of Birth (dd/mmm/yyyy)	Work Phone	
	Medical Plan Number	WCB / ICBC Claim Number	
	<input type="checkbox"/> MSP <input type="checkbox"/> WCB <input type="checkbox"/> ICBC <input type="checkbox"/> PATIENT <input type="checkbox"/> OTHER		

X-RAY
 ULTRASOUND
 CT
 INTERVENTIONAL PROCEDURES / ANGIO

EXAM REQUESTED:	
RELEVANT HISTORY:	REASON FOR EXAM:

IS PATIENT: Pregnant Yes No Date of LMP: _____
 Diabetic Yes No If so, is patient taking Glucophage (Metformin)? Yes No
 On Dialysis Yes No Taking Anti-Coagulants? Yes No _____
 (Please specify)

ALLERGIES: _____ Isolation: Standard Other: _____
 (Please specify) (Specify type)

IF PATIENT IS HAVING INTRAVENOUS CONTRAST PROCEDURE, PLEASE COMPLETE:

Recent eGFR (<3 months): _____ Date: _____

Recent Creatinine level: _____ Date: _____

Hx of contrast allergy reaction: (Please specify) _____

Physician: _____ (Signature / Stamp) Phone #: _____ Billing #: _____ Copies To: _____	RELEVANT PREVIOUS FILMS, IMAGES, RESULTS? Dr. has requested films/images: Y / N Date: _____ Location: _____ Date: _____ Attached: Reports <input type="checkbox"/> Lab Work <input type="checkbox"/> CD <input type="checkbox"/> Notes: _____
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• INCOMPLETE REQUESTS WILL BE RETURNED •
PORTION BELOW TO BE COMPLETED BY MEDICAL IMAGING

Priority <input type="checkbox"/> P1 <input type="checkbox"/> P2 <input type="checkbox"/> P3 <input type="checkbox"/> P4 <input type="checkbox"/> Specified date: _____ IV Contrast: <input type="checkbox"/> Yes <input type="checkbox"/> No Oral Contrast: <input type="checkbox"/> Yes <input type="checkbox"/> No Other: _____ Previous Films/Req: <input type="checkbox"/> Yes <input type="checkbox"/> No	Radiologist Protocol Mnemonic(s): _____ Booking: Technologist: <input type="checkbox"/> Films Notes: <input type="checkbox"/> Reports <input type="checkbox"/> Lab	_____ Date/Time Req. Rcv'd (dd/mmm/yyyy) Patient Type: <input type="checkbox"/> ER <input type="checkbox"/> IP <input type="checkbox"/> OP/OH Priority: 1 2 3 4 Specified date Discharge OH: _____ OP Related Delay: Y / N Dr. Office Related Delay: Y / N
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Stores #316455

