

REQUEST FOR DIAGNOSTIC CONSULTATION

Departments of Diagnostic Imaging, PEI

- QEH PCH KCMH
 Souris H CHO Western H

NAME: _____ CELL PHONE: _____ (SMS/text? Yes No)

MRN: _____ DOB: _____ SECONDARY PHONE: _____

ADDRESS: _____ E-MAIL ADDRESS: _____

- Emergency/Inpatient (Room/location): _____
 PORTABLE STRETCHER CHAIR LIFT REQUIRED WALK
 DVA RCMP WCB (Employer _____ Case # _____)

PRIORITY:

- Emergency Urgent
 Semi-Urgent Routine

EXAM REQUESTED (Include specific area of interest):

- General Radiography: _____
 CT Scan: _____
 Nuc Med: _____
 BMD: _____
 Mammography: _____
 Ultrasound: _____
 MRI: _____

***** COMPLETE REVERSE SIDE FOR MRI *******CT/Angio/MRI Procedures:**

CR/GFR: _____

Metformin: YES NO**MALIGNANCY?** YES NO

(Elaborate) _____

PREGNANT? YES NO

(LMP) _____

ALLERGIES: _____**PROVISIONAL DIAGNOSIS:****CLINICAL HISTORY:** _____**Relevant Previous Imaging:**

- CT: Yes No _____
 US: Yes No _____
 MRI: Yes No _____
 Nuc Med: Yes No _____
 X-ray: Yes No _____
 Mammo: Yes No _____

Tech: _____
 Fluoro time/CT DLP: _____
 # Images sent to PACS: _____
 # Exp: _____
 Pb used: _____
 Tech Notes: _____

Radiologist: _____

Priority P1 P2 P3

Protocol: _____

Contrast consent obtained by technologist: Yes No

Physician/NP Name (print): _____ Signature: _____

Date: _____ Office Phone #: _____ Fax #: _____

Extra Report To: _____ Fax #: _____

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