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 #: _____

101074.0005 (12/19)