

**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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