Eastern Health

Diagnostic Imaging

Request for Examination and Consultation

Name: ____________________

HCN: ____________________

Date of Birth: DD/MONTH/YYYY

Address: ____________________
Street/Town/Postal Code

Telephone: ____________________

❑ Inpatient – Unit ________ ❑ Outpatient

Patient Transport: ❑Bed ❑Stretcher ❑ Wheelchair

❑ MCP ❑ WCC ❑ NR ❑ DVA ❑ DND ❑ Other: ________

Physician Information (please use stamp)

The ordering physician is responsible to follow-up on the exam report.

Physician Signature: ____________________

Date: DD/MONTH/YYYY

Copy report to (please print): ____________________

Type of Exam Required

❑ Interventional ❑ Fluoroscopy ❑ Computed Tomography

❑ Radiography ❑ Ultrasound ❑ Nuclear Medicine/BMD

Specific Exam Requested: ____________________

Please Identify Urgency

Based on clinical assessment, Radiologist consult may be indicated.

❑ Urgent

❑ Non-urgent

❑ Follow-up (Specify Date): DD/MONTH/YYYY

❑ Screening (Specify Date): DD/MONTH/YYYY

Please indicate whether exam is being requested for a specific site or first available appointment. Please note that requesting a specific site may result in a longer wait time. ❑ First Available Appointment ❑ ____________ Specific Site (indicate site):

Clinical Information (where relevant)

Is patient on Warfarin, ASA or other anticoagulant?	❑ Yes	❑ No
Is patient receiving Metformin or Glucophage?	❑ Yes	❑ No
Has patient received IV contrast in the past?	❑ Yes	❑ No
Has patient had an adverse reaction to IV contrast?	❑ Yes	❑ No
Does the patient have contact precautions?	❑ Yes	❑ No
Has the patient had a Barium study within the past week?	❑ Yes	❑ No
Is the patient breastfeeding?	❑ Yes	❑ No

Please list allergies: ❑ None ____________________

LMP (for obstetrical use only): ____________________

Height: ____________ Weight: ____________

Complete for exams requiring IV Contrast:

Are there any of the following risk factors for contrast induced nephropathy (CIN)? ❑ Yes ❑ No

Risk Factors: Age greater than 70 years, Diabetes Mellitus, renal disease, Nephrotoxic drugs, organ transplant, chemotherapy, cardiovascular disease, single kidney.

If risk factor is present, please provide the patient's current* estimated GFR ____________

Date of last GFR: DD/MONTH/YYYY

**Outpatient: less than 6 months; Inpatient: less than 7 days*

Please list all relevant patient medications: ____________________

Clinical Indications for Exam (including previous relevant exams):

____

Clinical Diagnosis: ____________________

For Diagnostic Imaging Use Only

Ordering Physician Notified: ❑ *Phone* ❑ *Message* ❑ *Mail*

Exam Protocol: ____________________

Date Received: DD/MONTH/YYYY

Patient Preparation Instructions: ❑ *Yes* ❑ *No*

Patient Notified: ❑ *Phone* ❑ *Message* ❑ *Mail*

IV Contrast: ❑ *Yes* ❑ *No* *Sedation:* ❑ *Yes* ❑ *No*