fraserhealth

Community Birth Program

Surname	First Name	Sex M F F
Address		
City	Home Phone	
Date of Birth (dd/mm/yy)	Work Phone	
Medical Plan Number	WCB / ICBC Claim Number	
○ MSP ○ WCB ○ ICBC ○ PATIENT ○ OTHER		

Hospital Appt. Date Time

○ Not Willing to be booked at an alternate hospital

○ **Interpreter Needed?** Language _____

MEDICAL IMAGING REQUISITION

○ **X-RAY** ○ **ULTRASOUND** ○ **CT** ○ **INTERVENTIONAL PROCEDURES / ANGIO**

EXAM REQUESTED: **OB scan**

RELEVANT HISTORY:

REASON FOR EXAM:
dating ultrasound

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: _____ *(Please specify)* Isolation: ○ Standard Other: _____ *(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: Community Birth Program Tel 604-575-7275

RELEVANT PREVIOUS FILMS, IMAGES, RESULTS?
Dr. has requested films/images: Y/N Date: No
Location: _____ Date: _____
Attached: Reports ○ Lab Work ○ CD ○
Notes: _____

• INCOMPLETE REQUESTS WILL BE RETURNED •

PORTION BELOW TO BE COMPLETED BY MEDICAL IMAGING

Priority
❑ 1 Less than 7 days
❑ 2 Less than 30 days
❑ 3 Less than 60 days
❑ 4 Delayed follow-up

IV Contrast: ❑ Yes ❑ No

Oral Contrast: ❑ Yes ❑ No

Other: _____

Previous Films/Req: ❑ Yes ❑ No

Radiologist Protocol

Mnemonic(s):

Booking: Technologist:
❑ Films Notes:
❑ Reports
❑ Lab

Date/Time Req. Rcv'd (DD MM YY)

Patient Type: ❑ ER ❑ IP ❑ OP/OH

Priority: 1 2 3 4 Dis OH _____

OP Related Delay: Y / N

Dr. Office Related Delay: Y / N

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