Eastern Health
Diagnostic Imaging

Request for Examination & Consultation

IV1570 0776 01 2015

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.

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

Date of last GFR: DD/MONTH/YYYY

**Outpatient: less than 90 days; 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*
Date Received: DD/MONTH/YYYY
Patient Preparation Instructions: ❑ *Yes* ❑ *No*
Patient Notified: ❑ *Phone* ❑ *Message* ❑ *Mail*
IV Contrast: ❑ *Yes* ❑ *No* *Sedation:* ❑ *Yes* ❑ *No*

Exam Protocol: _____