

X-RAY REQUISITION

Last Name		First Name		Middle Initial	
Address			City	Province	Postal Code
Home Phone	Work Phone		PHN#	WCB#	
Date of Birth	Gender <input type="checkbox"/> F <input type="checkbox"/> M	Type of Exam Requested:		Pregnant <input type="checkbox"/> # of weeks: _____	Date of last menstrual cycle:

HISTORY

History and Clinical Diagnosis: (Please Include prior surgery, special instructions if any)	List Previous Relevant Exams (please submit images & reports).
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EXAMS REQUESTED / SPECIAL INSTRUCTIONS

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PHYSICIAN INFORMATION

Referring Physician (please print): _____	Date _____
Referring Physician Signature (required): _____	
College License #: _____ Phone#: _____	Fax#: _____
Additional Copies: _____	Priority: <input type="checkbox"/> Routine <input type="checkbox"/> Semi-Urgent <input type="checkbox"/> STAT
UCC Physician Impression: _____	

FOR DIAGNOSTIC IMAGING USE

Exam Date:	Notes:
Exam Time:	
# Images Taken:	# of Images sent to PACS
Pb Used:	Fluoro Time:
Pregnant:	Technologist: