



HEALTH CARE

- ST. PAUL'S HOSPITAL
1081 Burrard St., Vancouver, BC V6Z 1Y6
Phone: 604-806-8006 Fax: 604-806-8437
- MOUNT SAINT JOSEPH HOSPITAL
3080 Prince Edward Street,
Vancouver, BC V5T 3N4
Phone: 604-877-8323 Fax: 604-877-8132

MR MISS MRS MS PERMANENT ADDRESS	SURNAME	FIRST NAME		
POSTAL CODE	CELL PHONE	HOME PHONE	WORK PHONE	
DATE OF BIRTH (MONTH / DAY / YEAR)		AGE	SEX	
HEALTH CARE #	MSP <input type="checkbox"/>	WCB <input type="checkbox"/>	ICBC <input type="checkbox"/>	OTHER <input type="checkbox"/>

Appointment Date: _____ **Time:** _____

Infection Concerns? <input type="checkbox"/> YES <input type="checkbox"/> NO Specify: _____	X-Ray Exam Requested <div style="text-align: right;"><input type="checkbox"/> Remove Cast</div>				
Is the Patient Pregnant? <input type="checkbox"/> YES <input type="checkbox"/> NO	Relevant History / Reason for Exam (INCLUDE ANY MEDICATIONS) Tentative Diagnosis				
COMPLETE FOR INTERVENTIONAL PROCEDURES Previous IV Contrast Reaction? <input type="checkbox"/> YES <input type="checkbox"/> NO Reaction Type: _____					
Diabetes Mellitus? <input type="checkbox"/> YES <input type="checkbox"/> NO Must Have Creatinine Results For Diabetics. Renal Function? <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL eGFR (preferred): _____ or CREATININE: _____					
Allergies? <input type="checkbox"/> YES <input type="checkbox"/> NO Specify: _____					
DATE	SIGNATURE OF AUTHORIZING PHYSICIAN				
Please Print NAME					
Prac. No. _____					
ADDITIONAL COPY OF REPORT TO:					
For X-Ray Use Only					
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"></td> <td style="width: 50%;"></td> </tr> <tr> <td style="text-align: center;">TECH</td> <td style="text-align: center;">RAD</td> </tr> </table>			TECH	RAD
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