X-Ray

X-Ray Requisition

Providence 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	SURNAME	FIRST NAME	
PERMANENT ADDRESS			
POSTAL CODE	CELL PHONE	HOME PHONE	WORK PHONE
DATE OF BIRTH (MONTH / DAY / YEAR)		AGE	SEX
HEALTH CARE #	MSP ☐	WCB ☐	ICBC ☐ OTHER ☐

Appointment Date: _____ **Time:** _____

Infection Concerns?
☐ YES ☐ NO
Specify: _____

Is the Patient Pregnant?
☐ YES ☐ NO

X-Ray Exam Requested

☐ Remove Cast

COMPLETE FOR INTERVENTIONAL PROCEDURES

Previous IV Contrast Reaction?
☐ YES ☐ NO
Reaction Type: _____

Diabetes Mellitus?
☐ YES ☐ NO
Must Have Creatinine Results For Diabetics.

Renal Function?
☐ NORMAL ☐ ABNORMAL
eGFR (preferred): _____
or
CREATININE: _____

Allergies?
☐ YES ☐ NO
Specify: _____

Relevant History / Reason for Exam (INCLUDE ANY MEDICATIONS)

Tentative Diagnosis

DATE	SIGNATURE OF AUTHORIZING PHYSICIAN

Please Print NAME

_____ Prac. No. _____

ADDITIONAL COPY OF REPORT TO: _____

For X-Ray Use Only

	TECH	RAD

Form No. PHC – RA092 (R. May-07)