Shared health
Soins communs
Manitoba

Fax non-emergent requests to 204 926 3650
or toll-free to 1 866 210 6119 (outside Winnipeg)

☐ **ED Outpatient**

Patient's Last Name: _____

Patient's Contact #: _____

Time Order Placed: _____

☐ Follow-up with Emergency Physician

☐ Follow-up with Family Physician

DATE HRN

PATIENT

DOB

PROV HC#

DOCTOR

CLINIC/UNIT LOC'N

REQUEST FOR CONSULTATION FOR DIAGNOSTIC IMAGING EXAM

☐ **Outpatient**

☐ First appointment available (Winnipeg only)

☐ Will travel within Manitoba for first available appt or

☐ Preferred Site(s) _____

☐ **ER**

☐ **Inpatient** _____ (Site and Unit)

Date Exam Needed: _____ ACP #: _____

PATIENT INFORMATION

☐ IV_____ gauge ☐ **Interpreter required**

PHIN _____ **Sex** ☐ Male ☐ Female

Other Insurance No. _____ **WCB #** _____

Address _____

City _____ **Province** _____ **Postal Code** _____

Phone Home ( ) _____ **Work** ( ) _____ **Cell** ( ) _____

Emergency Contact/Next of Kin _____ **Maiden Name** _____

HISTORY AND EXAMINATION REQUESTED

(See Shared Health website for additional information and forms for Breast U/S; PET; Mammography, Bone Density)

Modality Requested (select one)

☐ **X-Ray** ☐ **Ultrasound** ☐ **CT** ☐ **Nuclear Medicine**

For MRI, see https://sharedhealthmb.ca/health-providers/diagnostic-services/imaging-central-intake/

PATIENT MOBILITY

☐ Wheelchair ☐ Stretcher ☐ Ambulatory ☐ Portable

☐ Gerichair ☐ Bed ☐ Will Require Lift

Examination Requested

URGENCY:

☐ Emergent (contact radiologist directly)

☐ Urgent

☐ Elective

☐ Specific date _____

Previous Relevant Exams Date Location

1. _____
2. _____
3. _____

History and Provisional Diagnosis

TB ☐ YES ☐ NO

Patient on Infection Control Precautions

ADDITIONAL PRECAUTIONS:

☐ **NONE** ☐ **YES (check ALL that apply):**

☐ Droplet ☐ Containment

☐ Contact ☐ Modified Protective

☐ Airborne ☐ Protective

CT: ACCURATE WEIGHT IF OVER 400 LBS

Patient Weight _____

Patient Height _____

Is patient pregnant? ☐ Yes ☐ No

LNMP _____ / _____ / _____ (dd / mm / yy)

Is patient nursing? ☐ Yes ☐ No

For invasive procedures:

INR (within 24 hours of exam) _____

Platelets (within 24 hours of exam) _____

FOR CONTRAST ENHANCED EXAMS

If contrast media is required, no solid food 4 hours prior to study. Normal fluid intake. If the patient is diabetic, please adjust medication accordingly.

"Allergy" to X-Ray dye ☐ Yes ☐ No

Contrast media can reduce renal function in patients with the following risk factors: *(check all that apply)*

☐ Kidney Disease ☐ Collagen Vascular Disease ☐ Receiving Metformin, Interleukin, NSAIDs

☐ Diabetes ☐ Myeloma ☐ Age > 65 years

For these "at risk" patients:

- provide Serum Creatinine (within 90 days of exam or 30 days if known renal disease) _____

- consider stopping NSAIDs, ACE inhibitors or other nephrotoxic medications prior to the procedures.

- stop Metformin 48 hours following IV contrast injection and check renal function prior to re-initiating medication.

AUTHORIZED CLINICIAN INFORMATION

Signature (Print and Sign) _____ MHSC Billing # _____

Address _____ Phone # _____ Fax # _____ Date _____

Extra Report To: _____ Fax # _____

Name/Address/Phone

Office Use Only Coding

Appointment Date/Time