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/

Examination Requested
URGENCY:
☐ Emergent (contact radiologist directly)
☐ Urgent
☐ Elective
☐ Specific date _____

PATIENT MOBILITY

☐ Wheelchair ☐ Stretcher ☐ Ambulatory ☐ Portable
☐ Gerichair ☐ Bed ☐ Will Require Lift

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