



DATE \_\_\_\_\_ HRN \_\_\_\_\_

PATIENT \_\_\_\_\_

DOB \_\_\_\_\_

PROV HC# \_\_\_\_\_

DOCTOR \_\_\_\_\_

CLINIC/UNIT \_\_\_\_\_ LOC'N \_\_\_\_\_

REQUEST FOR CONSULTATION FOR DIAGNOSTIC IMAGING EXAM

**Outpatient**  
 First Available Site Fax to:  
**DI Central Intake 204-926-3650**  
 or  
 Preferred Site(s) \_\_\_\_\_  
 (see reverse)

**ER**  
 **Inpatient** \_\_\_\_\_  
 (Site and Unit)

**Date Exam Needed:** \_\_\_\_\_ ACP #: \_\_\_\_\_

**PATIENT INFORMATION**

**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 WRHA 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 <http://wrha.mb.ca/prog/diagnostic/forms.php>

**Examination Requested**  
 Elective  
 Urgent  
 \*Note: For **emergent** outpatient exams, Radiologist must be contacted directly

**METHOD OF TRANSPORT**

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

Previous Relevant Exams	Date	Location
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

**History and Provisional Diagnosis.** **Patient on Infection Control Precautions?** **Specify**

**MUST COMPLETE FOR ALL EXAMS**

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: \_\_\_\_\_  
 Name/Address/Phone \_\_\_\_\_ Fax # \_\_\_\_\_

**Office Use Only** Coding \_\_\_\_\_  
 Appointment Date/Time \_\_\_\_\_