X-Ray

X-Ray Requisition

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

SURNAME	FIRST NAME				
PERMANENT ADDRESS					
CELL PHONE	HOME PHONE	WORK PHONE			
DATE OF BIRTH	AGE	SEX			
HEALTH CARE #	MSP	WCB	ICBC	OTHER	

Infection Concerns?
YES NO
Specify:

Is the Patient Pregnant?
YES NO

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:

X-Ray Exam Requested

Relevant History / Reason for Exam (INCLUDE ANY MEDICATIONS)

Tentative Diagnosis

DATE	SIGNATURE OF AUTHORIZING PHYSICIAN
Please Print NAME	

ADDITIONAL COPY OF REPORT TO:

For X-Ray Use Only

	TECH	RAD

Form No. PHC – RA092 (R. May-07)