TODAY'S DATE:



BC CHILDREN'S HOSPITAL RADIOLOGY CONSULTATION REQUEST 4480 Oak Street, Vancouver, B.C. V6H 3V4 (604) 875-2132, FAX: (604) 875-2367

	oo oak olieet, vancouver, b.o. vort	014 (004) 010 21	02, 1 AX. (004) 015	2007	
IMAGING REQUESTED:	PATIENT LOCATION:	MRN:			40000
Check one only X-ray/Fluoroscopy	Emergency			Date of Birth (D/M/Y)	Age
Cath Lab/IR	☐ Clinic/Outpatient	Surname	Given Name	Initial	
CT Scan	☐ OR	Address			
Ultrasound Nuclear Medicine	☐ Inpatient Ward:	City	Province	Postal Code	
☐ MR Scan	& Pt Room #:	PHN#			
Patient Screening Form MUST be attached	☐ B.C. Women's	Contact Numbers Required [H]:			
	Select if applicable:	[Office]	rs Hequired [H]:		
Review of Images	Request Portable	[Cell]			
OUTSIDE IMAGES FROM:	-1	DATE OF EXAM(S):		
EXAMINATION ORDERED:			ALLERGIES/SP	PECIAL INSTRUCT	IONS:
#)					
IS THE PATIENT SUSPECTED/CONFIRMED INFECTIOUS? YES NO					
IF YES, IS THE PATIENT: CONTACT DROPLET AIRBORNE SPECIFY:					
PERTINENT HISTORY: (NO EXAM IF NO PROVISIONAL DIAGNOSIS)					
*					
Patient's Height cm	Patient's Weight	len	Boto LICC T	ast Des DNss	
	Patient's Weight_	kg		est Pos Neg	
ATTENDING S BILLING # & PRINTE		AFF SIGNATURE resident, MSI)	EXTRA COPIES TO):	
ACCEPTED SHAPET AND DESCRIPTION OF A CONTROLLED CONTROLLED CONTROLLED CONTROLLED CONTROLLED CONTROLLED CONTROL		30-23000000	•		
VERBAL REPORT TO: (urgent rec	rugata anha)				
		OLIONE.			
DOCTOR	FOR RADIOLO	PHONE GY USE ONL	Y	PAGER #	100000000000000000000000000000000000000
TECHNOLOGIST'S COMMENTS:			RADIOLOGIST	ORDERS:	
Exam Date					
Exam Time					

Signature	_				
BOOKING/COMMENTS:					