

MEDICAL IMAGING REQUISITION

Patient Name (last) _____
 (first) _____
 DOB (dd/mmm/yyyy) _____
 PHN _____ MRN _____
 Account / Visit # _____
IH USE ONLY

BOOKING OFFICE USE	Appointment Date: _____	Time: _____	Date Received: _____
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IMPORTANT: Incomplete or illegible forms will be returned. Exam will be delayed or cancelled.

Patient Name (last) _____ (first) _____
 DOB (dd/mmm/yyyy) _____ PHN _____
 Patient Address _____
 City/Town _____ Province _____ Postal Code _____
 Phone (daytime) _____ Phone (other) _____ Phone (other) _____
 Patient Height _____ (cm) Patient Weight _____ (kg) Pregnant: Yes No Birth Sex: F M U
 Unavailable dates _____
 Billable to: MSP ICBC WorkSafeBC Claim # _____ Patient Other _____

<input type="checkbox"/> Ambulatory <input type="checkbox"/> Wheelchair <input type="checkbox"/> Mechanical lift PRIORITY LEVEL <input type="checkbox"/> P1 Emergent (Physician must speak with radiologist) <input type="checkbox"/> P2 Urgent <input type="checkbox"/> P3 Semi-urgent <input type="checkbox"/> P4 Non-urgent <input type="checkbox"/> P5 Date Specific	Name of ordering Practitioner & MSP Practitioner Number _____ Ordering Practitioner Phone: _____
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Radiography Exam Requested

Ultrasound Exam Requested (provide details of pregnancy test, where appropriate)

<input type="checkbox"/> Abdomen <input type="checkbox"/> Shearwave Elastography (for FIB-4 score greater than 1.35) <input type="checkbox"/> Renal/Bladder <input type="checkbox"/> Pelvis/Lower Abdomen <input type="checkbox"/> Obstetrical LMP: _____	<input type="checkbox"/> Aorta <input type="checkbox"/> Carotid <input type="checkbox"/> Thyroid	<input type="checkbox"/> Peripheral Venous <input type="checkbox"/> Arm <input type="checkbox"/> Leg <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Breast: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Axilla <input type="checkbox"/> Scrotal <input type="checkbox"/> Other (specify): _____
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Nuclear Medicine Exam Requested Diabetic Vascular Access Device Type of VAD _____

Pertinent History / Reason for Exam (Required)

Exams Requiring IV Contrast Known or suspected Renal Disease / Renal Failure or a Renal Transplant? <input type="checkbox"/> YES - Creatinine and eGFR are required within 90 days of appointment – please arrange <input type="checkbox"/> NO - No blood work required	Creatinine: _____ $\mu\text{mol/L}$ Est. GFR _____ mL/min Date: _____
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Date (dd/mmm/yyyy)	Time (24 hour)	Provider Name/Signature	Initials	Designation / College ID #
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FOR MEDICAL IMAGING DEPARTMENT USE ONLY

Copy Results To: _____
 Protocol / Instructions _____
 Radiologist Name _____

Permanent part of the health record

MEDICAL IMAGING REQUISITION

Radiography Only	Phone	Fax
100 Mile District General Hospital, 100 Mile	250-395-7615	250-395-7607
Arrow Lakes Hospital, Nakusp	250-265-3622	250-265-5224
Ashcroft Hospital & Community Health Centre, Ashcroft	250-453-2211	250-453-1926
Barriere Health Centre, Barriere	250-672-9731	250-672-5144
Chase Health Centre, Chase	250-679-3312	250-679-5329
Dr. Helmcken Memorial Hospital, Clearwater	250-674-2244	250-674-2477
Elk Valley Hospital, Fernie	250-423-4453	250-423-3732
Elkford Health Centre, Elkford	250-865-2247	250-865-2797
Invermere Hospital, Invermere	250-342-2322	250-342-2343
Kimberley Health Centre, Kimberley	250-427-2215	250-427-7389
Lillooet Hospital and Health Centre, Lillooet	250-256-1303	250-256-1302
Logan Lake Health Centre, Logan Lake	250-523-9414	250-523-6869
Nicola Valley Health Centre, Merritt	250-378-2242	250-378-3289
North Shore X-Ray Clinic, Kamloops (North Shore)	250-314-2420	250-376-8576
Pleasant Valley Health Centre, Armstrong	250-546-4700	250-546-8834
Princeton General Hospital, Princeton	250-295-4415	250-295-4066
Slocan Community Health Centre, New Denver	250-358-7911	250-358-7117
South Okanagan General Hospital, Oliver	250-498-5017	250-498-5098
South Similkameen Health Centre, Keremeos	250-499-3000	250-499-3001
Sparwood Health Centre, Sparwood	250-425-6212	250-425-0636
St. Bartholomew's Health Centre, Lytton	250-455-2221	250-455-6621
Summerland Health Centre, Summerland	250-404-8002	250-404-8005
Victorian Community Health Centre, Kaslo	250-353-2211	250-353-2747

LEGEND:

DOB	Date of Birth
GFR	Glomerular Filtration Rate
ICBC	Insurance Corporation of British Columbia
LMP	Last Menstrual Period
MSP	Medical Service Plan
PHN	Personal Health Number
VAD	Vascular Access Device
F	Female
M	Male
U	Unknown
cm	centimeter
kg	kilogram

Radiography & Ultrasound	Phone	Fax # 1	Fax # 2
Boundary Hospital, Grand Forks (Boundary)	250-443-2100	250-443-2164	250-354-2328 (US)
Castlegar & District Community Health Centre, Castlegar	250-304-1221	250-304-1235	
Creston Valley Hospital, Creston	250-428-3837	250-428-3833 (Rad)	250-417-3516 (US)
Golden Hospital, Golden	250-344-5271	250-344-3028 (Rad)	250-417-3516 (US)

Radiography, Fluoroscopy & Ultrasound	Phone	Fax # 1	Fax # 2
Cariboo Memorial Hospital, Williams Lake	250-302-3220	250-398-5892	
Kootenay Lake Hospital, Nelson	250-354-2316	250-354-2328	
Queen Victoria Hospital, Revelstoke	250-837-2131	250-814-2291 (Rad)	250-833-3628 (US / Fluoro)
Shuswap Lake General Hospital, Salmon Arm	250-833-3607	250-833-3628	

Radiography, Fluoroscopy, Nuclear Medicine & Ultrasound	Phone	Fax # 1	Fax # 2
East Kootenay Regional Hospital, Cranbrook	250-420-2495	250-426-5610 (Rad / Fluoro / NM)	250-417-3516 (US)
Kelowna General Hospital, Kelowna	250-862-4458	250-862-4357	
Kootenay Boundary Regional Hospital, Trail	250-364-3416	250-364-3435	
Penticton Regional Hospital, Penticton	250-492-9007	778-622-1828 (Rad / Fluoro / NM)	250-492-9094 (US)
Royal Inland Hospital, Kamloops	250-314-2400	250-314-2326	
Vernon Jubilee Hospital, Vernon (VJH)	250-558-1206	250-503-3721	

Permanent part of the health record