

**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**

Continue with 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:**

If yes to any above, please provide the most recent Creatinine result.

Serum Creatinine: \_\_\_\_\_ eGFR \_\_\_\_\_ Date \_\_\_\_\_ OR

Point of Care (whole blood Creatinine): \_\_\_\_\_ Date \_\_\_\_\_

**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 \_\_\_\_\_