



- All fields must be completed in order to process request
- Fax to Diagnostic Imaging; fax numbers listed at <http://www.albertahealthservices.ca/diagnosticimaging>
- Urgent/Emergent requests must be discussed by direct consultation with a radiologist

Last Name (<i>Legal</i>)		First Name (<i>Legal</i>)	
Preferred Name <input type="checkbox"/> Last <input type="checkbox"/> First		DOB(<i>dd-Mon-yyyy</i>)	
PHN	ULI <input type="checkbox"/> Same as PHN	MRN	
Administrative Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Non-binary/Prefer not to disclose (X) <input type="checkbox"/> Unknown	

Preferred Facility		Inpatient Location	
Patient Phone Number (<i>Cell # preferred</i>)		Patient Address	
City	Postal Code	WCB Claim Number	
Ordering Provider Name		Provider ID	Department ID
Provider Fax	Provider Phone	Contact Number for Critical Test Results	
Provider Address/Location		City	Postal Code
Locum <input type="checkbox"/> No <input type="checkbox"/> Yes ▶ Primary Provider Name and Provider ID _____			
Signature	Date (<i>dd-Mon-yyyy</i>)	Copy to Provider (<i>last,first and middle</i>)	Copy to Fax
Requested Procedure		Research Study <input type="checkbox"/> No <input type="checkbox"/> Yes Study Name: _____ Study #: _____	
Reason for Exam			
Clinical question to be answered			

Relevant Previous Imaging Studies

Modality	Location	Date (<i>dd-Mon-yyyy</i>)	Attached copy <input type="checkbox"/> No <input type="checkbox"/> Yes
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Current Patient Condition	No	Yes	Weight _____ <input type="checkbox"/> Kg <input type="checkbox"/> lbs	Height _____ <input type="checkbox"/> cm <input type="checkbox"/> in
Pregnant <input type="checkbox"/> n/a	<input type="checkbox"/>	<input type="checkbox"/>	Date of LMP (<i>dd-Mon-yyyy</i>)	
Pediatric/Special Needs	<input type="checkbox"/>	<input type="checkbox"/>	Requires sedation <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Anesthesia	
Isolation Precautions	<input type="checkbox"/>	<input type="checkbox"/>	Specify:	
Diabetic	<input type="checkbox"/>	<input type="checkbox"/>	Metformin (Glucophage) <input type="checkbox"/> No <input type="checkbox"/> Yes (<i>Patient may have to stop Metformin for 48 hours post contrast media injection</i>)	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	n/a	
History of a Severe anaphylaxis reaction	<input type="checkbox"/>	<input type="checkbox"/>	Carries an Epipen <input type="checkbox"/> No <input type="checkbox"/> Yes	
Allergies (<i>include any reaction to contrast media</i>)	<input type="checkbox"/>	<input type="checkbox"/>	Specify:	
Organ Transplant	<input type="checkbox"/>	<input type="checkbox"/>	Specify:	
Previous chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Specify:	
Power Compatible Port/PICC/CVC insitu	<input type="checkbox"/>	<input type="checkbox"/>	Specify:	
Mechanical lift/Transfer required	<input type="checkbox"/>	<input type="checkbox"/>	Specify:	
Vascular Disease (Hypertension, HF, etc)	<input type="checkbox"/>	<input type="checkbox"/>	Specify:	
Renal Disease or Solitary Kidney	<input type="checkbox"/>	<input type="checkbox"/>	Specify:	
Renal Insufficiency	<input type="checkbox"/>	<input type="checkbox"/>	Date of last GFR Result (<i>dd-Mon-yyyy</i>)	

On Dialysis <input type="checkbox"/> No <input type="checkbox"/> Yes	▶ <input type="checkbox"/> Hemodialysis <input type="checkbox"/> Peritoneal Dialysis	▶ <input type="checkbox"/> Acute Renal Failure <input type="checkbox"/> End Stage Renal Disease
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Serum Creatinine (<i>within 90 days</i>) _____	GFR (<i>within 90 days</i>) _____	Date (<i>dd-Mon-yyyy</i>) _____
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Department Use Only			
Date Received (<i>dd-Mon-yyyy</i>)	Time Received (<i>hh:mm</i>)	Date of Appointment (<i>dd-Mon-yyyy</i>)	Time of Appointment (<i>hh:mm</i>)
More info required <input type="checkbox"/> No <input type="checkbox"/> Yes ▶ Explain:		Protocol: IV Contrast <input type="checkbox"/> No <input type="checkbox"/> Yes	Oral Contrast <input type="checkbox"/> No <input type="checkbox"/> Yes
Priority <input type="checkbox"/> OP1 <input type="checkbox"/> OP2 <input type="checkbox"/> OP3 <input type="checkbox"/> OP4, Specify date:			Radiologist