Alberta Health Services

X-Ray Request

Last Name *(Legal)*	First Name *(Legal)*
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*
PHN / ULI ☐ Same as PHN / MRN	
Administrative Gender ☐ Male ☐ Female ☐ Non-binary/Prefer not to disclose (X) ☐ Unknown	

- Complete all fields for your request to be processed
- For Fluoro and Bone Mineral Densitometry (BMD) fax to Diagnostic Imaging; fax numbers listed at *http://www.albertahealthservices.ca/diagnosticimaging*
- For X-ray exams, send completed form with patient.

Important – Form is used for regular and downtime use.
Bold and italicized fields contain critical data elements that **must be reconciled** for downtime.

Preferred Facility		Patient Phone Number	
Inpatient Location		WCB Claim Number	
Ordering Provider Name *(last,first and middle)*		**Provider Phone**	
Provider Fax	**Contact Number for Critical Test Results**	Provider ID	Department ID
Provider Address/Location		City	Postal Code
Signature	Date *(dd-Mon-yyyy)*	Copy to Provider *(last, first,middle)*	Copy to Fax

STAT report requested ☐ No ☐ Yes ► specify phone/pager:

Requested Procedure

Reason for Exam

Clinical question to be answered

Relevant Previous Imaging Studies

Location	Type	Date *(dd-Mon-yyyy)*	Attached copy ☐ No ☐ Yes

Current Patient Condition	**No**	**Yes**	**If Yes**
Patient Pregnant	☐	☐	LMP: Beta HCG:
Isolation precautions	☐	☐	Specify type:
Allergies	☐	☐	Specify:
Mechanical lift/transfer required	☐	☐	Specify:
Research Study	☐	☐	Study Name: Study number:

Transportation ☐ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Oxygen ☐ Portable/Mobile
Patient type ☐ Outpatient ☐ Emergency ☐ Inpatient ► Patient Location:

Department Use Only *Date format: (dd-Mon-yyyy)*

Date Received	Time Received *(hh:mm)*	Appointment Date	Appointment Time *(hh:mm)*

Tech Notes

Patient Pregnant ☐ No ☐ Yes	LMP *(dd-Mon-yyyy)*	Comments

Radiologist	Tech	Fluoro Time *(mm:ss)*	Shielded ☐ No ☐ Yes	Number of Images

Tech Comments