Alberta Health Services

Nuclear Medicine Request

- All fields must be completed for form to be processed
- Fax to Diagnostic Imaging; fax numbers listed at *http://www.albertahealthservices.ca/diagnosticimaging*
- *Urgent/Emergent requests must be discussed by direct consultation with the radiologist*

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	

Preferred Facility		Inpatient Location	
Patient Phone Number *(Cell # preferred)*		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 ☐ No ☐ Yes ► Primary Provider Name and Provider ID _____			
Signature	Date *(dd-Mon-yyyy)*	Copy to Provider *(last,first and 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

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

Previous Treatment	**No**	**Yes**	**If Yes**
Chemotherapy	☐	☐	Where: When:
Radiation Therapy	☐	☐	Anatomical location: When:
Surgery	☐	☐	Anatomical location: When:
Current Patient Condition	**No**	**Yes**	**If Yes** ***Weight*** _____ ☐ Kg ☐ lbs ***Height*** _____ ☐ cm ☐ in
Pregnant ☐ n/a	☐	☐	Date of LMP: Date of BHCG:
Breastfeeding	☐	☐	n/a
Pediatric / Special Needs	☐	☐	Requires sedation: ☐ No ☐ Oral ☐ IV ☐ Anesthesia
Isolation Precautions	☐	☐	Specify Type:
Diabetes	☐	☐	n/a
Allergies	☐	☐	Specify:
Medications	☐	☐	Specify:
Mechanical lift/ transfer required	☐	☐	Specify:
Research Study	☐	☐	Study Name: Study number:

Nuclear Medicine Physician Only

Radiologist		Protocol	
Date Received *(dd-Mon-yyyy)*	Time Received *(hh:mm)*	Appointment Date *(dd-Mon-yyyy)*	Appointment Time *(hh:mm)*