Alberta Health Services

Nuclear Medicine Request

- 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*

Preferred Facility

No Preference

Patient label here or information below is required	
Last Name	First Name
Birthdate *(yyyy-Mon-dd)*	Gender
Address (street, city, province, postal code)	
PHN	Daytime Phone
Inpatient location	WCB Claim Number

Referring Physician *(**PRINT** first and last name)*	Physician Phone *(required)*	Physician Fax *(required)*	Contact Number for Critical Test Results *(required)*

Signature	Date *(yyyy-Mon-dd)*	Copy to Physician *(first and last)*	Copy to Fax

Specific anatomical area to be examined/name of exam

Relevant clinical history/presumptive diagnosis

Clinical question to be answered

Relevant Previous Imaging Studies

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

Previous Treatment

Treatment	No	Yes	If Yes:	
Chemotherapy	☐	☐	Where:	When:
Radiation Therapy	☐	☐	Anatomical location:	When:
Surgery	☐	☐	Anatomical location:	When:

Current Patient Condition Weight _____ ☐ Kg ☐ lbs Height _____ ☐ cm ☐ in

Condition	No	Yes	If Yes:	
Isolation Precautions	☐	☐	Specify type:	
Allergies	☐	☐	Specify:	
Medications	☐	☐	Specify:	
Breastfeeding	☐	☐	n/a	
Pregnant ☐ n/a	☐	☐	Date of LMP:	Date of BHCG:
Diabetes	☐	☐	n/a	
Mechanical lift/ transfer required	☐	☐	Specify:	
Research Study	☐	☐	Study name:	Study Number:

Patient type ☐ Outpatient ☐ Emergency ☐ Inpatient ► Patient Location:

Department Use Only Date format: *yyyy-Mon-dd* - Time format: *hh:mm*

Radiologist		Protocol	
Date Received	Time Received	Appointment Date	Appointment Time