Vancouver CoastalHealth
Promoting wellness. Ensuring care.

MEDICAL IMAGING REQUISITION

☐ X-Ray ☐ CT ☑ Ultrasound ☐ Echo ☐ Angiogram/Interventional ☐ Nuclear Medicine

Appointment Date: _____ Time _____ VCH Site _____

PATIENT INFORMATION

PHN 9067643002 ICBC _____

WCB _____ Other _____

Name: JUSH, Sean

Address: 1151 E. 55th Ave, Vancouver, BC V5R1S5

Tel: (604) 785-0802 Other: _____

Date of Birth: 02 Day 12 Month 1926 Year

Previous Images? Location: _____

practitioner

Dr. Jason M. Faulds
Vascular & Endovascular Surgeon
MSP: 65512
4226-2775 Laurel Street
Vancouver, BC, V5Z-1M9
P: 604 675-2431
F: 604 875-5542

Escort Required ☐ Nurse ☐ Porter ☐ Volunteer

Mode of transport ☐ WheelChair ☐ Stretcher ☐ Bed

Other ☐ O2 ☐ Isolation ☐ Portable ☐ IV Pump

DOCTORS TO COMPLETE THIS SECTION

EXAM(s) REQUESTED:

right brachial plexus ultrasound

Priority
☐ Routine
☐ Urgent
☐ Emergency

Physician must consult with Radiologist for Urgent and Emergency cases

Able to give consent? ☐ Yes ☐ No **If the patient does not speak English, an interpreter MUST accompany the patient**

Pt diabetic ☐ Yes ☐ No
On metformin ☐ Yes ☐ No
Breast Feeding ☐ Yes ☐ No
Pregnant ☐ Yes ☐ No
LMP _____
G _____ P _____ A _____
Height 152cm Weight 56kg
Previous contrast reaction?

PERTINENT HISTORY / MEDICATIONS

chronic right arm and neck pain. Referred for possible neurogenic TOS although not clinically consistent. Please assess for any dynamic brachial plexus compression

Physician's signature _____ Tel: 604 675-2431 Physician's MSP billing #: 65512

Copies of report to:
Lorenzon, Gabriella C. [07392]; Shah, Rita [64994]

This section MUST be completed if requesting CT

Is Kidney Function abnormal? ☐ Yes ☐ No Has patient had L-spine surgery? ☐ Yes ☐ No

If YES for any of the above **OR** if requesting a CT Abdomen/Pelvis **OR** Angiogram: a current (within 3 months) eGFR and Creatinine are **mandatory**

eGFR: _____ Date: _____

Creatinine: _____ Date: _____

This section MUST be completed for all Core Biopsies, Angiograms and Interventional Procedures

INR: _____ Date: _____

PLATELETS: _____ Date: _____

eGFR: _____ Date: _____

Creatinine: _____ Date: _____

* Does the patient take anticoagulant/ anti-platelet medication? ☐ Yes ☐ No

if yes please list medications:

*Patients may have to stop taking anticoagulant or anti-platelet medication prior to their appointment. If this is unsafe for your patient please consult a radiologist.

DEPARTMENT USE

Technologist: _____

Date: _____

No. of Images: _____

Fluoro Time / Dose: _____ / _____

Shielding used: _____

Technologist comments on reverse

fax 1 time
P3
DR. M. WOO
-09- 12 2022