Vancouver CoastalHealth
Promoting wellness. Ensuring care.

MEDICAL IMAGING REQUISITION

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

Any Site ☐ or Specify Site: SPH Appointment Date: _____ Time: _____

PATIENT INFORMATION

PHN 9828728823 ICBC _____
WCB _____ Other _____
Name: Janet Velle
Address: #106-600 Sero Street
Vancouver BC V7V 7H7
Tel: 604-603-7606 Other: _____
Date of Birth: 08 08 1888 M ☒ F ☐
Previous Images? Location: _____

PLACE MEDICAL IMAGING LABEL HERE

Escort Required ☐ Nurse ☐ Porter ☐ Volunteer
Mode of transport ☐ Wheelchair ☐ Stretcher ☐ Bed
Other ☐ O_2 ☐ Isolation ☐ Portable ☐ IV Pump

DOCTORS TO COMPLETE THIS SECTION

EXAM(s) REQUESTED:
CT abdomen

Physician should consult with Radiologist for Urgent and Stat cases

Priority
☒ Routine
☐ Urgent
☐ Stat

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

PI diabetic ☐ Yes ☒ No
On metformin ☐ Yes ☒ No
Breast Feeding ☐ Yes ☐ No
Pregnant ☐ Yes ☐ No
LMP _____
G _____ P _____ A _____
Height _____ Weight _____
Previous contrast reaction?

PERTINENT HISTORY / MEDICATIONS:
Previously diagnosed with pancreatic head cyst.
U/s recommended further imaging.

eGFR ordered.

Physician's signature Tel: 1-604-270-9833 Physician's MSP billing #: 60313

Copies of report to:

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: 81 Date: 28/03/2022
Creatinine: 99 Date: 28/03/2022

This section MUST be completed for all Core Biopsies, Angiograms and Interventional Procedures
INR: _____ Date: _____ * Does the patient take anticoagulant/anti-platelet medication? ☐ Yes ☐ No
PLATELETS: _____ Date: _____ If yes please list medications:
eGFR: _____ Date: _____
Creatinine: _____ Date: _____
*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

00083312, VCH.0020 June.2010