Vancouver CoastalHealth
Promoting wellness. Ensuring care.

MEDICAL IMAGING REQUISITION

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

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

PATIENT INFORMATION

PHN 9648-648-648 ICBC ICBC
WCB WCB Other
Name: Elalne Yainegaine
Address: 5555 Hudson Street
Vancouver, BC V4H 4B4
Tel: (604) 604-6604 Other: (604) 604-5604
Date of Birth: 29-Jun-1990 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:
URGENT REQUEST: CT ABDOMEN WITH CONTRAST *Recent CT CHEST at VGH/UBC reported findings/lesions of liver suspicious for metastatic disease
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**

Pt diabetic ☒ Yes ☐ No
On metformin ☒ Yes ☐ No
Breast Feeding ☐ Yes ☒ No
Pregnant ☐ Yes ☒ No
LMP
G P A
Height Weight
Previous contrast reaction?
GFR 40

PERTINENT HISTORY / MEDICATIONS:
CT ABDO with CONTRAST ***SUSPICIOUS LESIONS OF LIVER SEEN ON CHEST CT ***SUSPICIOUS FOR METASTATIC DISEASE Pt has significant fatigue and abdo pain, bloating, discomfort liver tender on exam Please characterize liver and do complete abdo/ pelvis

Intestinal infection, Campylobacter; GERD; DM; aortic sclerosis - ECHO(2020) due in 2022; Asthma - confirmed on methacholine challenge Feb 2019; Chronic kidney disease, unspecified; Diabetes Mellitus; Gastritis And Duodenitis, Other Gastritis; Hyperlipidemia; Migraine with aura; OA; Past History Note

Physician's signature Tel: 604-707-2273 Physician's MSP billing #: 63716

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: Date:

Creatinine: Date:

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

Technologist:

Date:

No. of Images:

Fluoro Time/Dose: /

Shielding used:

Technologist comments on reverse

MGV