

# UBC HOSPITAL

Vancouver Coastal Health Authority

2211 Wesbrook Mall, Vancouver, BC V6T 2B5

## DEPARTMENT OF RADIOLOGY

CT, RADIOLOGY, ULTRASOUND 604-822-7080 Fax 604-822-9701

NUCLEAR MEDICINE 604-822-7720 Fax 604-822-7894

MRI 604-822-7720 Fax 604-822-0702

DEPARTMENT USE ONLY

Appt Date \_\_\_\_\_

Time \_\_\_\_\_

PCIS Label here

Pt called with appt:

Date	Phone	Msg left

Medical Plan			
Surname		First Name	
Address			
City		Home Phone	
sex		Work Phone	
Date of Birth: day	mo	year	Cell Phone
Attending Physician			

Comments \_\_\_\_\_

Notified of perfume policy

Accession Number \_\_\_\_\_

**INCOMPLETE REQUISITIONS  
WILL BE RETURNED**

### Exam Requested

### Alternate Insurer and number

ICBC \_\_\_\_\_

WCB \_\_\_\_\_

Other \_\_\_\_\_

### For MRI Relative Contraindications

YES

NO

	YES	NO
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Aneurysm Clips	<input type="checkbox"/>	<input type="checkbox"/>
Implants	<input type="checkbox"/>	<input type="checkbox"/>
Pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Claustrophobia	<input type="checkbox"/>	<input type="checkbox"/>

Eye Injury Involving Metal  YES  NO

Metal Worker  YES  NO

Metallic Foreign Bodies  YES  NO

Specify type: \_\_\_\_\_

### For NUCLEAR MEDICINE

Height \_\_\_\_\_ cm Weight \_\_\_\_\_ kg

Medications \_\_\_\_\_

### Relevant History/Tentative Diagnosis

Physician \_\_\_\_\_ MD Dr's # \_\_\_\_\_

Name (Print) \_\_\_\_\_ Fax # \_\_\_\_\_

Copies To \_\_\_\_\_ Copies To Fax # \_\_\_\_\_

Previous Films Requested

CT MRI Plain

Date	Date
Place	Place

Office use only: Radiologist's Orders