Providence HEALTH CARE **X-Ray** **RADIOLOGY**

OUTPATIENT X-RAY REQUISITION

Fax to 604-806-8437

MR MISS MRS MS	Surname	First name
Permanent address		
Postal code	Cell phone	Home phone / Work phone
DOB	Age	Sex
Care Card Number (PHN)	☐ MSP ☐ WSBC ☐ ICBC ☐ Other	

APPOINTMENT DATE: _____ **ARRIVAL TIME:** _____

Infection precautions: ☐ None
☐ Contact
☐ Droplet
☐ Airborne
☐ Airborne & Contact
☐ Droplet & Contact

Is the patient pregnant:
☐ Yes ☐ No

Allergy/Intolerance Status:
Refer to completed Caution Sheet

X-Ray exam requested:

☐ Remove cast

Previous IV contrast reaction:
☐ Yes ☐ No

Diabetes:
☐ Yes ☐ No
Must have creatinine results for diabetics

Renal function:
☐ Normal ☐ Abnormal
Date of collection: _____
eGFR (preferred): _____
∗OR∗
Creatinine: _____

Reason for exam / Relevant history: (include any medications)

Tentative diagnosis

Authorizing Physician: Date of request: _____ Additional copies of report to:

Printed name _____ Signature _____

College ID _____ Pager # _____