Thunder Bay Regional Health Sciences Centre

Riverside Health Care

DRHC Dryden Regional Health Centre

Lake of the Woods District Hospital

Diagnostic Imaging

RADIOLOGY
CONSULTATION REQUEST

Regional Inpatient? **Yes** ☐ **No** ☐
Patient will walk in? ☐ **Please schedule appointment** ☐
Is the patient hearing impaired? **Yes** ☐ **No** ☐
Appointment Date: _____ **Time:** _____

Guidelines:

1. Physician to complete requisition. Incomplete requisitions will be returned resulting in delay of study.
2. Requisition is to be **faxed to location** where the x-ray is to take place-(check one):

   ☐ TBRHSC Diagnostic Imaging Central Intake **855-978-1862** ☐ Dryden Diagnostic Imaging 807-223-8854
   ☐ Riverside Diagnostic Imaging 807-274-4837 ☐ Lake of the Woods District Hospital Diagnostic Imaging 807-468-2367
3. If any clarifications required, contact the Booking Office at 807-684-5856 (Thunder Bay only). Lake of the Woods (Kenora only) at 807-468-9861 Ext. 2201.

Patient Name: _____ ☐ In-Patient ☐ Out-Patient

Address: _____ Date of Birth _____ /_____ /_____
day month year

_____ Postal Code: _____

Home Phone Number: _____ Work Phone Number: _____ Sex: ☐ Male ☐ Female

Health Insurance Card Number: _____ Version Code: _____

Workplace Safety and Insurance Board (WSIB) Claim Number: _____

Employer: _____ Accident Date: _____

Area to be examined:

1. _____
2. _____

Clinical Information: _____

_____

Does cast need to be removed prior to x-ray? ☐ Yes ☐ No

- Is the patient pregnant? ☐ Yes ☐ No
  Date of Last Menstrual Period: _____
- Does the patient have allergies? ☐ Yes ☐ No
  If yes, specify: _____
- For patients requiring intravenous contrast injection:
  Is the patient diabetic? ☐ Yes ☐ No
  Is the patient on Metformin? ☐ Yes ☐ No
  Does the patient have known kidney disease? ☐ Yes ☐ No

List medication(s): _____

Recent estimated Glomerular Filtration Rate (eGFR) Level (within one month) _____
Date: _____

PRIORITY ASSESSMENT:

☐ **1** – **Immediate** - Emergent
☐ **2** – **Within 48 Hours** - Inpatient/Urgent
☐ **3** – **Within 10 Days** - Semi-urgent
☐ **4** – **Within 4 Weeks** - Non-urgent

TECHNOLOGIST USE ONLY:

Physician's Name (please print): _____
Physician's Signature: _____ **Date:** _____