Alberta Health Services

# X-Ray Request

| Patient label placed here *(if applicable)* or if labels are not used, minimum information below is required | |
|---|---|
| Last Name | First Name |
| Birthdate *(yyyy-Mon-dd)* | Gender |
| PHN # | Phone # |

- Facilities and phone numbers can be found at http://alberthealthservices.ca/facilities.asp
- Urgent/Emergent requests must be discussed by direct consultation with the radiologist

| Referring Physician *(Print first and last name)* | Physician Phone | Physician Fax |
|---|---|---|
| Physician Signature | Copy to Physician | Copy to Fax |
| Stat Report Requested<br>☐ No<br>☐ Yes ▶Specify Pager/Phone # _____ | Transportation ☐ Portable<br>☐ Wheelchair ☐ Walk<br>☐ Stretcher ☐ O2 | ☐ Inpatient<br>☐ Outpatient<br>☐ Emergency Department |

**Exam Requested**

| Specify | Isolation/Precautions<br>☐ Droplet ☐ Contact ☐ Airborne | Date Requested *(yyyy-Mon-dd)* |
|---|---|---|

Specific anatomical area to be examined

Abdomen

Relevant Clinical History/Presumptive Diagnosis

Clinical question to be answered

**Relevant Previous Imaging Studies** *(Mandatory for Mammography)*

| Location | Type | Date (yyyy-Mon-dd) | Attached copy |
|---|---|---|---|
| | | | |

**Tech Notes**

| Date of Exam *(yyyy-Mon-dd)* | | Radiologist | LMP | Patient Pregnant<br>☐ No ☐ Yes |
|---|---|---|---|---|
| Tech | Fluoro Time *(hh:mm)* | Sheilded ☐ No ☐ Yes | Number of Images | |

**Tech Comments**

**Department Use Only**

| Booking Date *(yyyy-Mon-dd)* | Booking Time *(hh:mm)* |
|---|---|