REQUEST FOR RADIOLOGICAL CONSULTATION

NAME _____ _____
Surname First

SEX ___ H.F.# _____

DOB _____

ADDRESS _____
Street Apt.

_____
City Prov. Postal Code

Patient Identification

EXAMINATION DATE: _____

Patient's Home Phone # _____ Business Phone # _____

PATIENT BILLING DATA

Health Card Number _____
OHIP Number: _____
Holder Relation: _____
Subscriber Name _____

Circle Where Applicable:
IOH - INPATIENT OTHER HOSPITAL
S - SELF PAY
N - SELF PAY (NON-RESIDENT)
WCB - WORKER'S COMPENSATION
U - UNKNOWN

- ☐ Emergency/Trauma
- ☐ Inpatient Nursing Unit ____
- ☐ Outpatient Clinic/Room ____
- ☐ Other Hospital

REFERRING PHYSICIAN DATA

Physician In Charge _____
Clinic Or Room _____
Referring Phys OHIP Number _____

Referring Physician's Address If Private Patient
_____
Referring Physician's Phone Number If Private Patient
_____

TEST PRIORITY: (SELECT ONE)

- ☐ Stat (Requires approval Call 4336)
- ☐ Urgent (ASAP)
- ☐ Routine

TRANSPORTATION: (SELECT ONE)

- ☐ Ambulatory
- ☐ Wheelchair
- ☐ Stretcher
- ☐ Operating Room
- ☐ Portable

PATIENT INDICATORS

- ☐ Diabetic
- ☐ Epileptic
- ☐ Intravenous
- ☐ Possible blood & body fluid (BBFP)
- ☐ No Restrictions
- ☐ Isolation
- ☐ Oxygen
- ☐ Renal Disease

EXAM(S) REQUESTED

1) _____
2) _____
3) _____
4) _____
5) _____

(PERTINENT CLINICAL HISTORY)

_____
_____
_____
_____

Signature of Physician _____

SPACE BELOW FOR USE OF RADIOLOGY DEPARTMENT ONLY

RCP DATE	TIME	ROOM	TECH I.D.
___/__/___ yy mm dd	_____ 24 hr. clock	_____	_____

EXAM NAME	OHIP CODE	Film Size	Number	Film Size	Number	Film Size	Number
1. _____	_____	_____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____	_____	_____	_____

8006 - 2602 (5 - 91)