Elysian Health

200 - 2626 Croydon Dr.
Surrey BC V3Z 0S8
imaging@elysianhealth.ca
www.elysianhealth.ca
Phone: 604.256.3010
Fax: 778.613.2656

PATIENT IMAGING REQUISITION

Please complete ALL parts. Please include relevant previous MRI, CT, X-ray, and Ultrasound Reports
When completed FAX TO: 778.613.2636

FIRST NAME: ________________________________ LAST NAME: ______________________________

PHN:____________________________ DOB:________________________ WEIGHT________________ LBS/KG

HEIGHT__________M/FT SEX: _______ MOBILE PHONE: (______)____________ HOME PHONE: (______)____________

ADDRESS: ____ CITY: ________________________

PROVINCE: _______________ POSTAL CODE:_______________

CT Scan ◯ Bone Density ◯

- EXAM REQUESTED:

  ____

- RELEVANT HISTORY, SYMPTOMS & TENTATIVE DIAGNOSIS:

  ____

  ____

  ____

- Is the patient pregnant? **YES/NO** Date of LMP: ______________________________________
- Is the patient Diabetic? **YES/NO** If yes, is the patient taking Glucophage? (Metformin)? **YES/NO**
- Is the patient on Dialysis? **YES/NO** Taking Anti - Coagulants? **YES/NO** ___________________________

- Allergies: ____

If the patient is having an intravenous contrast procedure

- Recent eGFR (<3 Months): ____ Date: _________________________
- History of contrast allergy: **YES/NO** If yes, specify: ____

Contrast Allergy: Elysian Health is an outpatient facility. We are unable to accommodate patients with a known contrast allergy, even if pre-medicated, the risk of serious allergy requires a referral to the hospital.

REQUESTING PHYSICAN: ________________________________ SIGNATURE: _______________________________________

MSP #:____________________ PHONE: (______)_______________ FAX: (______)__________________

E-Mail (PACS)______________________________

ADDITIONAL COPIES OF REPORT TO: _______________________________________ FAX: (______)_________________