Elysian Health

Imaging and Diagnostics
Suite 200- 2626 Croydon Drive
Surrey, BC, V3Z 0S8
Phone (604) 256-3010
Fax (778) 613-2656
imaging@elysianhealth.ca

MEDICAL IMAGING REQUISITION

SURNAME	FIRST NAME	SEX
ADDRESS		DATE OF BIRTH
CELL PHONE	HOME PHONE	PHN

☐ ULTRASOUND ☐ ECHO ☐ CT ☐ BONE DENSITY ☐ JOINT PAIN INJECTION

EXAM REQUESTED:

RELEVANT HISTORY/INDICATION/ TENTATIVE DIAGNOSIS: (include relevant results from x-ray, CT, US, Angio, MRI, Nuclear Medicine)

ULTRASOUND REQUESTED (provide details of pregnancy test where appropriate)

☐ Abdomen ☐ Obstetrical LMP: ____________________ ☐ Breast ☐ R ☐ L ☐ Axilla
☐ Renal/Bladder ☐ Vascular (specify): __________________ ☐ MSK (specify): ________________
☐ Groin ☐ Scrotum ☐Pelvis /TV
☐ Thyroid ☐ Other: _________________________

Is patient: Pregnant ☐YES ☐NO Date of LMP: ____
Diabetic ☐ YES ☐ NO If yes, on Glucophage (metformin)? ☐YES ☐NO
On Dialysis ☐ YES ☐ NO Taking Anti-Coagulants? ☐ YES ☐NO

ALLERGIES: ____

NOTE: Elysian is an outpatient facility and unable to accommodate patients with known contrast allergies despite premedication. Please refer to a hospital for scanning a patient with contrast allergy

If patient requires intravenous contrast:
Recent eGFR (within 3 months): ____________________________ Date: __________________________
History of contrast allergy? ☐ YES ☐NO (please specify) _______________________________________

ECHO: Standard ECHO only, No TEE or contrast. Please include details of prothesis of Aortic, Mitral and Tricuspid valves including Manufacturer, size and date implanted: ______________________________________
____

Physician: ____
Signature/ Stamp

Phone: ___________________________ Fax: ____________________

Copies to:
____

Billing: __________________

Previous Relevant Imaging: ☐YES ☐ NO	Location:	Date:	Results:

Radiologist Protocol:	Approved by:

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