Pureform Radiology

REQUISITION

APPOINTMENT DATE:

CALGARY NORTHWEST FAX: 403.261.9968 (CROWFOOT)
CALGARY SOUTHEAST FAX: 403.726.9883 (SOUTH TRAIL)
AIRDRIE FAX: 403.945.9985

APPOINTMENT BOOKING: 403.726.9729
(Booking open from 7:30am - 5:00pm)
URGENT BOOKING: 403.984.1500
(Urgent booking for medical staff only)

PATIENT INFORMATION (Place Patient Label Here)

Name: ____________________
Address: ____________________
Phone (Res): ____________________
AHC#: ____________________
DOB (D/M/Y): ____________________ Gender: Male ☐ Female ☐
City/Province: ____________________ Postal Code: __________
Work/Cell: ____________________
WCB#: ____________________

☐ PATIENT HISTORY

☐ X-RAY (No Appointment Necessary)

Exam Requested: ____________________

☐ MAMMOGRAPHY

☐ Diagnostic ☐ Screening

☐ BONE DENSITY

☐ Hip ☐ Spine ☐ BMD

☐ BIOPSIES

☐ Breast Biopsy ☐ Thyroid Biopsy ☐ Other: __________

☐ PEDIATRIC ULTRASOUND

☐ Abdomen ☐ Thyroid ☐ Pylorus
☐ Pelvis ☐ Neck ☐ Spine (under 4 months)
☐ Kidneys & Bladder ONLY ☐ Scrotum ☐ Cranial (Fontanelle must be open)
☐ Inguinal ☐R ☐L ☐ Bilateral Hips (under 4 months)
☐ Other: __________

☐ GENERAL ULTRASOUND

☐ Abdomen
☐ Pelvis
☐ Thyroid ☐ Neck
☐ Scrotum
☐ Breast ☐ R ☐ L
☐ Inguinal/Hernia ☐ R ☐ L
☐ Kidney/Bladder
☐ Other: __________

☐ PREGNANCY ULTRASOUND (Check All That Apply)

1st Trimester
☐ Dating/Viability
☐ Nuchal Translucency

2nd Trimester & 3rd Trimester
☐ Detailed Anatomical Survey >18 weeks
☐ BPP and growth ☐ Growth and position only
☐ BPP post dates
☐ Other (specify indication): __________

-We will schedule the exams at the correct time.-

☐ MUSCULOSKELETAL

☐ Shoulder ☐R ☐L ☐ Elbow ☐R ☐L
☐ Knee ☐R ☐L ☐ Wrist ☐R ☐L
☐ Ankle ☐R ☐L ☐ Other: __________
☐ Hip ☐R ☐L

☐ VASCULAR ULTRASOUND

☐ Carotid Arteries
☐ Venous (DVT) leg: ☐R ☐L Arm: ☐R ☐L
☐ Other: __________

☐ PAIN MANAGEMENT / INJECTIONS

Site: __________
Injection: __________

REFERRING PRACTITIONER INFORMATION

Name: ____________________
Signature: ____________________
Copy To: ____________________
☐ STAT Phone Report: ____________________
☐ Stat Fax Report: ____________________

-Practitioner's ID / Stamp-

☐ Send images with patient (CD copy)