Alberta Health Services

X-Ray/Fluoroscopy Request

- All fields must be completed for form to be processed
- For Fluoro and Bone Mineral Densitometry (BMD) fax to Diagnostic Imaging; fax numbers listed at *http://www.albertahealthservices.ca/diagnosticimaging*
- For X-ray exams, send completed form with patient.

Last Name *(Legal)*	First Name *(Legal)*
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*
PHN	ULI ☐ Same as PHN / MRN
Administrative Gender ☐ Male ☐ Female ☐ Non-binary/Prefer not to disclose (X) ☐ Unknown	

Preferred Facility		Inpatient Location
Patient Phone Number *(Cell # preferred)*		Patient Address
City	Postal Code	WCB Claim Number
Ordering Provider Name	Provider ID	Department ID
Provider Fax	Provider Phone	Contact Number for Critical Test Results
Provider Address/Location	City	Postal Code
Locum ☐ No ☐ Yes ► Primary Provider Name and Provider ID _____		
Signature	Date *(dd-Mon-yyyy)* / Copy to Provider *(last,first and middle)*	Copy to Fax
STAT report requested ☐ No ☐ Yes ► specify phone/pager:		
Requested Procedure		
Reason for Exam		
Clinical question to be answered		

Relevant Previous Imaging Studies

Modality	Location	Date *(dd-Mon-yyyy)*	Attached copy ☐ No ☐ Yes

Current Patient Condition	**No**	**Yes**	**If Yes:**
Patient Pregnant	☐	☐	LMP: Beta HCG:
Isolation precautions	☐	☐	Specify type:
Allergies	☐	☐	Specify:
Anticoagulants/Bleeding Disorder	☐	☐	Specify:
Mechanical lift/transfer required	☐	☐	Specify:
Research Study	☐	☐	Study Name:

Transportation ☐ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Oxygen ☐ Portable/Mobile
Patient type ☐ Outpatient ☐ Emergency ☐ Inpatient ► Patient Location:

Department Use Only

Date Received *(dd-Mon-yyyy)*	Time Received *(hh:mm)*	Appointment Date *(dd-Mon-yyyy)*	Appointment Time *(hh:mm)*

Tech Notes

Patient Pregnant ☐ No ☐ Yes	LMP *(dd-Mon-yyyy)*	Radiologist	Technologist	Fluoro Time *(mm:ss)*

Shielded ☐ No ☐ Yes	**Comments**
Number of Images	