London Health Sciences Centre

RADIOLOGIC CONSULTATION

SITE: ☐ University Hospital ☐ Victoria Hospital

PIN: _____ UNIT: _____ ROOM #: _____

NAME: _____ (Last) (First)

ADDRESS: _____

SEX: _____ BIRTHDATE: _____ (YYYY/MM/DD) AGE: _____

OHC#: _____ VERS. CODE: _____

Previous exam at LHSC: ☐ Yes ☐ No (if no, indicate where & date)

Where: _____ YYYY/MM/DD

Portable: ☐ **Yes** ☐ **No**

Patient Type: ☐ IP ☐ OP ☐ Emerg ☐ Research ☐ Ins/Legal

Research Number: _____ Project Name: _____

Insurance/Legal Name & Address: _____

ORDERING PHYSICIAN INFORMATION: Name (with initials) ***must*** be legible.

Print Name: _____

Address: _____

Fax: _____ Beeper#: _____

Telephone: _____ OHIP# (if new): _____

☐ WSIB Claim#: _____

Date of Injury (YYYY/MM/DD): _____

Employer & Address: _____

ALLERGIES: ☐ NKA ☐ Contrast ☐ Latex

☐ Other: _____

EXAM INFO:

DAY: _____ DATE: _____ (YYYY MM DD) TIME: _____ (HH:MM)

Pregnant: ☐ **Yes** ☐ **No** LMP: _____ (YYYY MM DD)

Precautions / Patient Flag: ☐ **Yes** ☐ **No** **Type:** _____

Radiology Examination(s) Requested:

Clinical History and Specific Information Required:

Physician's Signature: _____

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