Shared health
Soins communs
Manitoba

☐ **ED Outpatient**

Fax non-emergent requests to 204 926 3650
or toll-free to 1 866 210 6119 (outside Winnipeg)

Patient's Last Name: ______________________________
Patient's Contact #: ______________________________
Time Order Placed: ______________________________
☐ Follow-up with Emergency Physician
☐ Follow-up with Family Physician

DATE | HRN
PATIENT
DOB
PROV HC#
DOCTOR
CLINIC/UNIT | LOC'N

REQUEST FOR CONSULTATION FOR DIAGNOSTIC IMAGING EXAM

☐ **Outpatient**
- ☐ First appointment available (Winnipeg only)
- ☐ Will travel within Manitoba for first available appt
  or
- ☐ Preferred Site(s) ______________________

☐ **ER**

☐ **Inpatient** ______________________ (Site and Unit)

Date Exam Needed: _____ ACP #: _____

PATIENT INFORMATION

☐ **IV**__________ **gauge** ☐ **Interpreter required**

PHIN ______________________________ **Sex** ☐ Male ☐ Female
Other Insurance No. ________________ **WCB #** ______________________________
Address ____
City ______________________ **Province** _____ **Postal Code** ______________
Phone Home (   ) __________ **Work** (   ) ___________ **Cell** (   ) __________
Emergency Contact/Next of Kin ______________ **Maiden Name** ______________

HISTORY AND EXAMINATION REQUESTED

(See Shared Health website for additional information and forms for Breast U/S; PET; Mammography, Bone Density)

Modality Requested (select one)
☐ **X-Ray** ☐ **Ultrasound** ☐ **CT** ☐ **Nuclear Medicine**

For MRI, see https://sharedhealthmb.ca/health-providers/diagnostic-services/imaging-central-intake/

PATIENT MOBILITY

☐ Wheelchair ☐ Stretcher ☐ Ambulatory ☐ Portable
☐ Gerichair ☐ Bed ☐ Will Require Lift

Examination Requested

URGENCY:
- ☐ Emergent (contact radiologist directly)
- ☐ Urgent
- ☐ Elective
- ☐ Specific date ________________

Previous Relevant Exams	Date	Location
1.		
2.		
3.		

History and Provisional Diagnosis

TB ☐ YES ☐ NO

Patient on Infection Control Precautions

ADDITIONAL PRECAUTIONS:

☐ **NONE** ☐ **YES (check ALL that apply):**

☐ Droplet ☐ Containment
☐ Contact ☐ Modified Protective
☐ Airborne ☐ Protective

CT: ACCURATE WEIGHT IF OVER 400 LBS

Patient Weight ______________________
Patient Height ______________________
Is patient pregnant? ☐ Yes ☐ No
LNMP _______ / _______ / _______ (dd / mm / yy)
Is patient nursing? ☐ Yes ☐ No

For invasive procedures:
INR (within 24 hours of exam) ______________
Platelets (within 24 hours of exam) __________

FOR CONTRAST ENHANCED EXAMS

If contrast media is required, no solid food 4 hours prior to study. Normal fluid intake. If the patient is diabetic, please adjust medication accordingly.

"Allergy" to X-Ray dye ☐ Yes ☐ No

Contrast media can reduce renal function in patients with the following risk factors: *(check all that apply)*

☐ Kidney Disease ☐ Collagen Vascular Disease ☐ Receiving Metformin, Interleukin, NSAIDs
☐ Diabetes ☐ Myeloma ☐ Age > 65 years

For these "at risk" patients:
- **provide Serum Creatinine (within 90 days of exam or 30 days if known renal disease)** ________
- consider stopping NSAIDs, ACE inhibitors or other nephrotoxic medications prior to the procedures.
- stop Metformin 48 hours following IV contrast injection and check renal function prior to re-initiating medication.

AUTHORIZED CLINICIAN INFORMATION

Signature (Print and Sign) ______________________ MHSC Billing # ______________

Address ______________ Phone # ______________ Fax # ______________ Date ______________

Extra Report To: ______________________________ Fax # ______________
Name/Address/Phone

Office Use Only Coding

Appointment Date/Time ______________

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