London Health Sciences Centre

RADIOLOGIC CONSULTATION

SITE: ☐ University Hospital ☐ Victoria Hospital

PIN: ______ UNIT: ______ ROOM #: ______

NAME: ______
Last First

ADDRESS: ______

SEX: ______ BIRTHDATE: ______ AGE: ______
YYYY/MM/DD

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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