Canada Diagnostic Centres

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Referral Form CT☐ MRI☐ U/S☐

This form MUST be fully completed before an appointment is booked. Incomplete forms will be returned.

Patient

Patient Name _____

Address _____

City _____ Code _____

Tel _____ Bus _____

Birth Date: Yr _____ Mth _____ Day _____ ☐ Female ☐ Male

P.H.N. _____

Doctor

Doctor Name _____

Address _____

City _____ Code _____

Tel _____ Fax _____

Additional Reports

Additional Copies of Report to be sent to:

Name _____

Address _____ Fax _____

Name _____

Address _____ Fax _____

Yes	No	Patient Questionnaire
☐	☐	**1.** Is there a chance the patient may be pregnant? Indicate date of last menstrual period _____
☐	☐	**2.** How much does the patient weigh? _____ lbs or _____ kg
☐	☐	**3.** Has the patient had previous surgery? If yes, what type _____ _____
☐	☐	**4.** Has the patient ever been a grinder, metal worker or welder?
☐	☐	**5.** Has the patient ever had a metallic foreign body in their eye? **If yes**, please provide an orbital x-ray report prior to appointment.
		6. Does the patient have any of the following:
☐	☐	Cardiac pacemaker?
☐	☐	Aneurysm clip?
☐	☐	Neurostimulator?
☐	☐	Cochlear implants
☐	☐	Tattoos or body piercing?
☐	☐	Other implanted device(s) or metallic objects in body? Explain _____ _____ _____
☐	☐	**7.** Is the patient claustrophobic?
☐	☐	**8.** Has the patient had heart surgery? (Bypass, Bypass graft, Coronary graft, CABG, Stents)
☐	☐	**9.** Does the patient have allergies? If yes, please list _____ _____ _____
☐	☐	**10.** Does the patient have diabetes mellitus? If yes, are they on Insulin? _____ On Metformin? _____
☐	☐	**11.** Does the patient have a history of significant kidney disease? **If yes to #10 or #11, please indicate most recent serum creatinine**
☐	☐	**12.** Is the patient fully mobile?

Examination Required

Area(s) to be examined: 1. _____ 2. _____ 3. _____

Results of relevant examination/surgical procedures. Please fax any previous reports.

Clinical History _____

_____

_____

_____
Physician's signature

Protocol (for internal use only)

Protocol _____

_____

IV Contrast ☐ Yes ☐ No

Oral Contrast ☐ Yes ☐ No ☐ Telebrix ☐ Water

Fax: 604-709-6112