St. Michael's HealthCare Services
Mobile X-Ray Requisition

13930 – 74 Street, Edmonton, AB T5C 3H7

Telephone: (780) 472-4504 **Fax: (780) 472-4799** Cell: (780) 616-1089 (Jack) (780) 288-3247 (Marina)

SERVICES AVAILABLE 7 DAYS/WEEK MON-SUN

Patient Information:

Name:_____

DOB:_____

AHC # _____

PLACE PATIENT LABEL HERE

Name of Facility:_____Unit / Room #_____

Address of Facility:_____Is this LTC☐ or SL☐

Contact Name:_____Phone Number:_____

Type of Exam:

_____

_____

_____

Reason for Exam/Pertinent Patient History:

_____

_____

_____

CLINICAL PRIORITY:

_____**STAT** **(Take within 4 hrs)** -Life Threatening - Possible Hip Fracture - Possible Transfer to Hospital - Serious Problem Affecting Medication Treatment Plan -Other (explain)

_____**ASAP** **(24 Hours)** - Rule out Infection - Possible Minor Fracture/Dislocation - Other (explain)

_____**ROUTINE** - Follow Up X-Ray - On-going Pain -Arthritis - Other (explain)

Is the Patient/Client pregnant? Yes/No LMP_____Is Patient/Client on Isolation? Yes/No

Physician Information (First and Last Name) **Prac. ID:**_____

Physician's Name: _____

Address _____

Fax Results Fax # _____

Technologist' Comments and Technique used:

_____

_____

X-Ray Code(s):_____ **X-Ray Date/ Time**_____

No. Images:_____ **Patient Shielded:** **YES / NO**

Revised 02/19