



**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 MON-SAT 8-4pm

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
- ASAP (24 Hours)** - Serious Problem Affecting Medication Treatment Plan -Other (explain)
- ROUTINE** - Rule out Infection - Possible Minor Fracture/Dislocation - Other (explain)
- 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