



CANADA MOBILE X-RAY INC. (REQUISITION) – CALGARY

118 Nolandshire Crescent NW
Calgary AB T3R 0P8

Tel: 1-800-813-3650
Fax: 1-888-276-7619

THIS EXAM IS FOR A
FUTURE DATE OF:

ALL AREAS MUST BE COMPLETED OR PLACE LABEL

FIRST NAME LAST NAME GENDER: **M** **F** **OTHER**

D.O.B (MM/DD/YYYY) HEALTHCARE# PROVINCE

STREET ADDRESS APT/SUITE/OTHER

FACILITY INFORMATION (PLEASE PRINT CLEARLY)

FACILITY NAME UNIT

CONTACT NAME PHONE FAX

EXAM REQUESTED

INDICATE APPROPRIATE ORDER STATUS:

ROUTINE

ASAP

STAT

X-RAY

L R UPPER LIMB

- Shoulder
- Acromioclavicular
- Sternoclavicular
- Elbow
- Wrist
- Hand
- Finger _____

SPINE

- C-Spine
- T-Spine F/E Views
- L-Spine
- Sacroiliac Joints
- Scoliosis Series

L R UPPER LIMB

- Hip
- Knee
- Ankle
- Foot
- Toe _____
- Femur
- Tib/Fib

OTHER

- Chest
- Abdomen
- Pelvis
- Skeletal Survey
- Other _____

DIAGNOSTIC ULTRASOUND

L R VASCULAR

- Carotid
- DVT Leg Arm

GENERAL

- Abdomen
- Bladder
- Scrotum
- Thyroid
- Neck
- Renal
- Lump site

PHYSICIAN INFORMATION (PLEASE PRINT CLEARLY)

PHYSICIAN NAME PRACTICE ID#

STREET ADDRESS

CITY PROVINCE POSTAL CODE

PHONE FAX

TECH INITIALS # OF FILMS #OF REPEAT FILMS

TECHNIQUE USED KVP mAs PATIENT SHIELDED

TECH COMMENTS