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

118 Nolanshire Crescent NW
Calgary AB T3R 0P8

Tel: 1-800-813-3650
Fax: 780-401-3352

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 _____

L R UPPER LIMB
- Hip
- Knee
- Ankle
- Foot
- Toe _____
- Femur
- Tib/Fib

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

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