External Diagnostic Imaging Consultation Request

Department of Diagnostic Imaging
Tel. 613 969-7400 x2860 (BGH)
FAX 613-969-5561

REQUESTING PHYSICIAN

Name: ______________________

Signature: ______________________

Date (dd/mm/yy):

INCOMPLETE AND ILLEGIBLE REQUESTS WILL BE RETURNED

Please include relevant imaging reports from outside centres.

Patient Data:

Patient Name:______________________
Patient Date of Birth: ______________________
Health Card Number: ______________________
Patient Phone Number:______________________
Patient Address: ______________________
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REQUESTED RADIOLOGIST:

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☐ **Breast Consultation - derived from requested assessment/intervention**

☐ **Interventional Radiology Consultation - derived from requested assessment/intervention**

☐ **Clinical Consultation – image review to facilitate clinical management**

Please provide an opinion in regards to:

PLEASE COMPLETE:

LOCATION OF IMAGES FOR CONSULT:

____

IMAGES AND REPORTS REQUESTED FOR CONSULT:

☐	MRI	DATE: _______
☐	CT	DATE: _______
☐	US	DATE: _______
☐	MAMMO	DATE: _______
☐	GEN RAD	DATE: _______

OFFICE USE ONLY

Consult Received Date: ______________

Images & Report Requested:	Yes ○	No ○	Date: ______________
Images & Report in PACS:	Yes ○	No ○	Date: ______________
Consultation in PACS:	Yes ○	No ○	Date: ______________