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

13930 – 74 Street, Edmonton, AB T5C 3H7

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

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 **-Life Threatening - Possible Hip Fracture - Possible Transfer to Hospital - Serious Problem Affecting Medication Treatment Plan -Other (explain)**

___ASAP **- 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 01/26