505-750 West Broadway | Vancouver, BC V5Z 1 H4
T: 604-879-4177 | F: 604-879-4147

Digital X-Ray & General Ultrasound Requisition

FIRST NAME	SURNAME	
ADDRESS	DATE OF BIRTH (MM/DD/YY)	SEX □ MALE □ FEMALE □ OTHER
CELL PHONE	HOME PHONE	WORK PHONE
PERSONAL HEALTHCARE # (PHN)	PAYMENT INFORMATION □ MSP □ ICBC □ WCB □ OTHER CLAIM #: _____	

Appointment Date: _____ **Time**: _____

EXAMINATION REQUESTED	**CLINICAL INFORMATION**	
PRIORITY □ Routine □ Urgent □ Stat		
RELEVANT PREVIOUS EXAM □ CT □ MRI □ Ultrasound □ Other: _____ Date: _____ Location: _____		
ORDERING PHYSICIAN	BILLING #	DATE
SIGNATURE OF ORDERING PHYSICIAN	CC REPORT TO	