

GENERAL DIAGNOSTIC IMAGING REQUISITION

PATIENT INFORMATION:

NAME: HOME PHONE:
 ADDRESS: WORK / MOBILE PHONE:
 CITY / PROVINCE: POSTAL CODE: DATE OF BIRTH (D/M/Y):
 AHC: WCB: ASSIGNED SEX AT BIRTH: M F
 CURRENT GENDER IDENTITY:

X-RAY (Walk-In, No Appointment Necessary):

EXAM REQUESTED:

REASON FOR REFERRAL / CLINICAL QUESTION TO BE ANSWERED:

PREGNANT: Y N
 LMP:

EXAM PREPARATION

X-RAY: These exams are performed on a walk-in basis. Wear loose fitting clothes without any metal in the area to be scanned. Please remember to bring the requisition, your Alberta Health Care Card and photo ID to your appointment.

REFERRER INFORMATION

NAME: PRAC ID:
 ADDRESS: CLINIC / FACILITY NAME:
 PHONE: FAX:
 LOCUM: Y N If yes, primary practitioner and Prac. ID:

SIGNATURE: _____

REPORT OPTIONS

STAT PHONE REPORT COPY TO: FAX:
 STAT FAX REPORT

LOCATION

**PHASE 1, SECOND FLOOR
 WEST EDMONTON MALL (Entrance 31)**
 Unit 2052 8882 – 170 Street,
 Edmonton, Alberta, T5T 3J7

780-902-3255
 athleticare@zerone.ca

