Sunnybrook
MEDICAL IMAGING

Request for Radiological Consultation

Name: _____

Gender: _____ Date of birth: _____
(YYYY/MM/DD)

Address: _____
Street Apartment

_____
City Province Postal code

PATIENT IDENTIFICATION

Patient's home phone #: _____ Business phone #: _____

OHIP #: _____ Version code: _____ Current location/clinic: _____

PHYSICIAN DATA AND CLINICAL INFORMATION

Most responsible physician: _____ Requesting physician: _____

Most responsible physician's office phone #: _____ Requesting physician's office phone #: _____

Clinic or room: _____ Requesting physician's OHIP billing #: _____

Ordering phone and fax #: _____

TEST PRIORITY (select one): ☐ Emergent ☐ Urgent ☐ Semi-urgent ☐ Routine

EXAM(S) REQUESTED	PERTINENT CLINICAL HISTORY
1)	
2)	
3)	
4)	
5)	
Physician (PRINT NAME): _____ Signature of physician: _____ Date (YYYY/MM/DD): _____	

SPACE BELOW FOR USE OF DEPARTMENT OF SUNNYBROOK MEDICAL IMAGING ONLY

EXAM(S) DESCRIPTION/ RIS CODE	SD #	ACCESSION #	COMPLETION TIME (hh:mm)	RESOURCE	TECH ID(S)
1)					
2)					
3)					
4)					
5)					
Dose information of administrations and pharmaceuticals: _____					

THIS REQUISITION HAS NOT BEEN PROCESSED FOR THE FOLLOWING REASON(S):

☐ Writing is illegible ☐ Fax is illegible ☐ Request is incomplete ☐ Physician signature is missing

☐ Physician information is missing/incomplete ☐ Area to be examined is missing ☐ Clinical history is missing/incomplete

☐ Patient information is incomplete: Name; Full address with postal code; Phone #; OHIP # with version code

Legend: # - Number RIS - Radiology Information System SD - System Downtime OHIP - Ontario Health Insurance Plan

D80062602

8006 2602
(2019/10/03)

PLEASE FILL OUT ALL SECTIONS LEGIBLY.
ILLEGIBLE OR INCOMPLETE FORM WILL BE RETURNED.