St. Joseph's Health Care LONDON

FOR RADIOLOGY DEPT. USE ONLY

ROOM NUMBER

SURNAME _____

GIVEN NAME _____

☐ EMERGENCY ☐ URGENT ☐ ELECTIVE ☐ RESEARCH

ADDRESS _____

DATE OF BOOKED EXAM _____ V.C.

POSTAL CODE _____

O.H.C. # _____

TEL.#(HOME) _____ (WORK) _____

D.O.B. _____ Yr. Month Day

WCB EMPLOYER _____

ADDRESS _____

☐ AMBULATORY
☐ WHEEL CHAIR
☐ STRETCHER
☐ PORTABLE

S.I.N. # _____

ACCIDENT DATE _____

AREA TO BE EXAMINED: _____

IF THIS IS A SCREENING MAMMOGRAM / OBSP ☐
PLEASE CHECK

DIAGNOSIS SUSPECTED: _____

CLINICAL FINDINGS AND HISTORY: _____

ALLERGIES: **SEE ALLERGY RECORD**

IF PATIENT HAS KNOWN LATEX ALLERGY, PLEASE NOTIFY OUR OFFICE AS SOON AS POSSIBLE AT 646-6044.

DATE OF LAST MENSTRUAL PERIOD: _____

PREV. EXAM

X-RAY ☐	NUC. MED ☐	U.S. ☐
ST. JOE'S ☐	ST. JOE'S ☐	ST. JOE'S ☐
OTHER ☐	OTHER ☐	OTHER ☐

LOCATION IF OTHER _____

DR. SIGNATURE _____ DATE _____

DR. SIGNATURE - PLEASE PRINT _____

FAMILY PHYSICIAN _____