ULTRASOUND PATIENT REQUISITION & FAX FORM

Please fax completed form to Canadian Magnetic Imaging at 604.733.4424

Patient Information: Patient MRN: _____ (cmi use only)

Patient Name: _____ Phone Res: _____

Address: _____ Phone Work: _____

_____ Phone Cell: _____

Age: _____ Date of Birth: _____ Sex: _____ Weight: _____
(Day/Month/Year)

History/Symptoms:

_____

_____

_____

_____

Area to Examine:

_____

_____

Looking for:

_____

_____

Referring Physician: _____

Direct Line Phone No.: _____ Fax No.: _____

Physician's Address: _____

City: _____ Province: _____ Postal Code: _____

_____
Referring Physician's Signature

Additional copies of report to: _____ Fax No.: _____

_____ Fax No.: _____

Date Request Received: _____
(cmi use only)

Hycroft Centre, 18-3195 Granville Street, Vancouver, BC V6H 3K2
tel 604.733.5563 toll free 1.877.268.8530 fax 604.733.4424 WWW.CANMAGNETIC.COM