Central Alberta
Medical Imaging Services

P: 403-755-8061 | F: 403-309-0093 | www.camiscare.ca
info@camiscare.ca

NUCLEAR MEDICINE REQUEST FORM

Appt Date/Time _____

Patient Information

Name _____
Address _____
City _____
Province _____ Postal Code _____

Phone Home _____ Alt _____

DOB (D/M/Y) _____ M ☐ F ☐
A.H.C.# _____
WCB Claim # _____
Date of Injury (D/M/Y) _____

Clinical information (Required) _____

☐ Bone Scan
☐ HIDA (Hepatobiliary) +GBEF
☐ Parathyroid
☐ Miraluma
☐ MUGA

Referring Physician

Stat Report ☐

Name _____
Address _____
_____
Phone _____ Fax _____

PRAC ID _____
Signature _____
CC _____
_____ Fax _____