

## GENERAL 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)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### X-ray (no appointment necessary - Monday through Friday 7:15 am - 6:00 pm)

Exam(s) requested \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Ultrasound Locations

(NOTE: X-ray, Breast Imaging, Ultrasound Guided Biopsy, and Bone Mineral Densitometry available ONLY at the Red Deer location.)

#### Red Deer

Phone: 403-343-7459  
Fax: 403-309-0092

#### Sylvan Lake

Phone: 403-864-0130  
Fax: 403-864-0131

#### Olds

Phone: 403-556-3554  
Fax: 403-556-8933

#### Stettler

Phone: 403-742-2240  
Fax: 403-742-1188

### Ultrasound (Please provide history)

#### Pregnancy

- Single  Twin  
 Dating / Viability  
 Nuchal Translucency (11-13w 6d)  
 Detailed Anatomic Survey >18 weeks  
 Biophysical Profile >=28 weeks  
 Other \_\_\_\_\_

#### General

- Abdomen  
 Pelvis  
 Thyroid  Neck  
 Scrotum  
 Hernia  OR  L  
 Kidney / Bladder  
 Superficial Mass \_\_\_\_\_  
 Other \_\_\_\_\_

#### Vascular

- Echocardiography (Heart) >15 years  
 Carotid Arteries  
 Venous Leg (DVT)  R  L  
 Venous Arm (DVT)  R  L  
 Limited Ankle Brachial Indices (ABI)  
 Other \_\_\_\_\_

### Breast Imaging

#### Mammography

- Screening (no clinical signs or symptoms)  
 Diagnostic (Please provide history)  
 Galactography (Please provide history)

#### Breast Ultrasound

- Breast Ultrasound  R  L  
 Axilla Ultrasound  R  L

#### Ultrasound-Guided Biopsy

- US Guided Breast Biopsy  R  L  
 US Guided Breast Cyst Asp.  R  L  
 US Guided Prostate Biopsy

### Bone Mineral Densitometry

- Bone Densitometry  Body Composition (uninsured service)

### Referring Physician

Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_

#### Stat Report

PRAC ID \_\_\_\_\_  
Signature \_\_\_\_\_  
CC \_\_\_\_\_  
\_\_\_\_\_ Fax \_\_\_\_\_