Central Alberta
Medical Imaging Services

P: 403-755-8061 | F: 403-309-0093 | www.camiscare.ca
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NUCLEAR MEDICINE REQUEST FORM

Appt Date/Time ____________________

Patient Information

Name ______________________________ M ☐ F ☐ Other ☐

Address ______________________________ DOB (D/M/Y) ____________________

City ______________________________ A.H.C.# ____________________

Province ____________ Postal Code ____________ WCB Claim # ____________________

Phone Home ____________ Alt ____________ Date of Injury (D/M/Y) ____________________

Clinical information (Required) ______________________________

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☐ Bone Scan ☐ Parathyroid ☐ MUGA

☐ HIDA (Hepatobiliary) +GBEF ☐ Miraluma

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Referring Physician

Stat Report ☐

Name ______________________________ PRAC ID ____________________

Address ______________________________ Signature ____________________

______________________________ **CC** ____________________

Phone ____________ Fax ____________ ____________ Fax ____________