	Shared <b>health</b>	DATE	HRN
	Soins communs Manitoba	PATIENT	
Fax non-emergent requests to 204 926 3650		50	
	Outpatient or toll-free to 1 866 210 6119 (outside Winn	. 5/	
Patient's Last Name:		1110111011	
Patient's Contact #:		DOCTOR	
Time Order Placed: ☐ Follow-up with Emergency Physician			
☐ Follow-up with Family Physician		CLINIC/UNIT	LOC'N
刀	☐ Outpatient	PATIENT INFORMATION	☐ IV gauge ☐ Interpreter required
Ш	☐ First appointment available (Winnipeg only) ☐ Will travel within Manitoba for first available appt	PHIN	
D	or □ Preferred Site(s)	Other Insurance No.	WCB #
	□ ER	Address	
Щ	□ Inpatient		Province Postal Code
TS	☐ Inpatient(Site and Unit)		Work ( ) Cell ( )
_	Date Exam Needed: ACP #:	Emergency Contact/Next of Ki	n Maiden Name
T	HISTORY AND EXAMINATION REQUEST	ED	PATIENT MOBILITY
유	(See Shared Health website for additional information and forms		
刀	Modality Requested (select one)	For MRI, see https://sharedhealthmb.ca/health-providers/	☐ Wheelchair ☐ Stretcher ☐ Ambulatory ☐ Portable
$\bigcup_{i \in \mathcal{I}_i} C_i$	□ X-Ray □ Ultrasound □ CT □ Nuclear Medicine	diagnostic-services/imaging-central-intake/	☐ Gerichair ☐ Bed ☐ Will Require Lift
0	Examination Requested URGENCY:		Previous Relevant Exams Date Location
Z	☐ Emergent (contact radiologist directly)		1
S	☐ Urgent☐ Elective☐		2
1	☐ Specific date		3
<b>'</b>	History and Provisional Diagnosis  TB □YES □NO  Patient on Infection Control Precautions		
>			
$\overline{\mathbf{H}}$	ADDITIONAL PRECAUTIONS:		
0			
Ž	□ NONE □ YES (check ALL that apply):		
п	☐ Droplet ☐ Containment ☐ Contact ☐ Modified Protective		
Ö	☐ Airborne ☐ Protective		
X	L'Alibonie L'Flotective		
	CT: ACCURATE WEIGHT IF OVER 400 LBS	OR CONTRAST ENHANCED EXAM	1S
밀	Patient weight		
	diabetic, please adjust medication accordingly.		
GNOSTIC	"Allergy" to X-Ray dye ☐ Yes ☐ No Is patient pregnant? ☐ Yes ☐ No Contrast media can reduce renal function in patients with the following risk factors: (check all that apply)		
Z			
Q	LNMP/   Kidney Disease		
S	Is patient nursing?		
C			
=			
7	AUTHORIZED CLINICIAN INFORMATION		
MAGIN	AUTHORIZED CLINICIAN INFORMATION		
$\stackrel{\hookrightarrow}{=}$	Signature (Print and Sign)		MHSC Billing #
Z			g //
G	Address	Phone # Fax #	Date
Ш	Extra Report To:		
$\times$	Name/Address/Phone		Fax #
	Office Use Only Coding		
<b>Z</b>			
			Appointment Date/Time