



Patient Label

Patient Name: (last) _____ (first) _____
Date of Birth: (d/m/y) _____ Male / Female
Phone home: _____ work: _____ cell: _____
Address: _____
Health Care Number: _____ WCB Case number: _____

Examination: please circle

Left	Distal Humerus	Distal Femur
Right	Elbow	Knee
Bilateral	Forearm	Ankle
	Wrist	Tibia
	Hand	Foot
	Finger(s)	Toe(s)

Other: _____

Patient History: please circle

Activity: Skiing / Snowboarding / Mtn Bike / Running / Hockey / Skateboard / Baseball
Other: _____

Mechanism of Injury: please circle

Direct Impact	Slow Twisting Fall	Hyperextension
FOOSH	Fell Backwards	Hyperflexion
Inversion	Eversion	Other: _____

Date of Injury/Length of Pain: _____

Looking for/Suspected Injury? _____

Relevant prior exams: _____

Safety Screening Questions:

Please circle any applicable

Cardiac Pacemaker
Cochlear implants
Aneurysm clip
History of Metal in eyes
Allergies

Other surgically
(Implanted

device(s)(metallic/electronic/magnetic)

Referring Physician Stamp

Ordering number _____

Referring Physician Signature

Date: _____

Additional copies to: _____

Fax # _____

URGENT / STAT

Reports will be sent by fax. Please make sure your fax number is on this requisition form.

FOR OFFICE USE ONLY:

Date request received: _____ Date of Booking: _____ Appt Time: _____

Protocol: _____