

# X-RAY REQUISITION (Weight Bearing)

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Last Name		First Name		Middle Initial	M / F
Address		City	Province	Postal Code	
DOB: (mm/dd/yy)		Home Phone		Work Phone	
PHN:		Type of Exam Requested:			
Pregnant Y / N	If Yes # of Weeks:		Date of Last Menstruation (Mandatory)		

## HISTORY / PRIOR EXAMINATION INFORMATION:

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## EXAMS REQUESTED / SPECIAL INSTRUCTIONS

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## REFERRING CHIROPRACTOR

Referring Chiropractor Name:		Phone No:		Fax No:	
Signature:		Billing Number	Priority:	<input type="checkbox"/> Routine <input type="checkbox"/> Semi-Urgent <input type="checkbox"/> STAT	
Copies To:		UCC Physician Impression:			Date:

## FOR DIAGNOSTIC IMAGING USE

Exam Date:	Notes:
Exam Time:	
# Images Taken:	# of images sent to PACS
Pb Used:	Fluoro Time:
Pregnant:	Technologist:



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