

St. Joseph's Health Care LONDON

FOR
RADIOLOGY
DEPT. USE
ONLY



ROOM NUMBER _____

SURNAME _____

GIVEN NAME _____

ADDRESS _____

POSTAL CODE _____

TEL. # (HOME) _____ (WORK) _____

WCB EMPLOYER _____

ADDRESS _____

S.I.N. # _____

ACCIDENT DATE _____

EMERGENCY

URGENT

ELECTIVE

RESEARCH

DATE OF BOOKED EXAM _____

V.C. _____

O.H.C. # _____

D.O.B. _____
Yr. Month Day

AMBULATORY

WHEEL CHAIR

STRETCHER

PORTABLE

AREA TO BE EXAMINED: _____

IF THIS IS A SCREENING MAMMOGRAM / OBSP

PLEASE CHECK

DIAGNOSIS SUSPECTED: _____

CLINICAL FINDINGS AND HISTORY: _____

ALLERGIES:

SEE ALLERGY RECORD

**IF PATIENT HAS KNOWN
LATEX ALLERGY, PLEASE
NOTIFY OUR OFFICE AS SOON
AS POSSIBLE AT 646-6044.**

DATE OF LAST MENSTRUAL PERIOD: _____

PREV. EXAM

X-RAY

NUC. MED

U.S.

ST. JOE'S

ST. JOE'S

ST. JOE'S

OTHER

OTHER

OTHER

LOCATION IF OTHER _____

DR. SIGNATURE _____ DATE _____

DR. SIGNATURE - PLEASE PRINT _____

FAMILY PHYSICIAN _____