Lennox & Addington County General Hospital

DIAGNOSTIC IMAGING– **EXTERNAL CONSULTATION**

Tel: 613-354-3301 x263

Fax: 613-354-4331

Patient Name:

DOB:
HCN:
Address:

Phone/Cell #:

WSIB #:

[Affix patient label here]

Physician Name:_____

Physician Signature:_____

Physician Contact #: _____

Date of Referral: _____

Requested Radiologist, if applicable:
_____

PLEASE SUBMIT IMAGING ON CD WITH FINAL REPORTS

☐ **MRI** Consultation Image Facility:_____	Exam Date:_____	Images & Reports Sent (Circle): YES NO
☐ **CT** Consultation Image Facility:_____	Exam Date:_____	Images & Reports Sent (Circle): YES NO
☐ **ULTRASOUND** Consultation Image Facility:_____	Exam Date:_____	Images & Reports Sent (Circle): YES NO
☐ **X-ray** Consultation Image Facility:_____	Exam Date:_____	Images & Reports Sent (Circle): YES NO

Imaging Clarification/Consultation of Clinical Interest:

OFFICE USE ONLY

Consult Received Date: _____

Images & Report Requested:	○ YES	○ NO	Date:_____
Images & Report Received:	○ YES	○ NO	Date:_____
Consultation in PACS:	○ YES	○ NO	Date:_____