HEADWATERS Health Care Centre

Patient Label

# REFERRAL FOR CONSULTATION ON OUTSIDE IMAGING STUDIES

**Booking Office**
**Phone**: 519-941-2410 Ext. 2211
**Fax**: 519-941-7726

If you would like to consult with a specific Radiologist, please indicate, otherwise the referral will be assigned to a radiologist by the department.

Radiologist Requested:

| | | |
|---|---|---|
| Referring Physician: | Patient Name: | |
| Referring Physician Signature: | Address: | |
| Referring Physician Telephone Number: | Telephone: | |
| Referring Physician Billing Number: | Patient Date of Birth: (dd/mm/yyyy) | Gender<br>○ Male<br>○ Female<br>○ Other |
| | Patient Health Card Number: | HHCC H# (If applicable) |

Reason For Referral:

- ☐ Evaluation prior to Biopsy
- ☐ Second opinion on outside imaging studies
- ☐ Other: _____

Relevant History:

Please indicate modalities submitted for consultation (check all that apply):

- ☐ Xray
- ☐ Ultrasound
- ☐ Nuclear Medicine
- ☐ CT
- ☐ MRI
- ☐ Mammogram

*Investigation to date:*

**NOTE:** Images (on digital format) or Films & Report(s) from other institutions **MUST BE SUBMITTED** with this form.