BRANT COMMUNITY HEALTHCARE SYSTEM
RADIOLOGY REQUISITION

☐ BGH Site
200 Terrace Hill St
Brantford, ON N3R 1G9

☐ Willett Site
238 Grand River St. N.
Paris, ON N3L 2N7

Tel: 519-751-5599
Fax: 519-751-5582

Requisition must be brought to appointment or for walk in visit

Name _____
Last First Initial

Address _____

Date of Birth _____
Day Month Year

Telephone Home: _____

Other: _____

Health Card # _____

WSIB ☐ _____

Other ☐ _____

Patient requires assistance – Wheelchair ☐ Mechanical Lift ☐

Verbal Report Requested ☐ **(USE DISCRIMINATELY PLEASE)**	DATE OF APPOINTMENT:	TIME:

Examination(s) Requested			
HISTORY AND CLINICAL INFORMATION MUST BE COMPLETED			
For Contrast, Biopsy and Invasive Procedures	Is patient on blood thinners? YES ☐ NO ☐ If Yes, please list:		
	ALLERGIES OR PREVIOUS REACTION TO CONTRAST AGENTS?		
	DATE OF LMP:		
Ordering Physician	Important Please Print	Name Fax	Signature
Extra Copies of report to be sent to:	DR. Fax		DR. Fax

HEALTHCARD MUST BE PRESENTED AT TIME OF EXAM

Revised April 2017 Form # 7402

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