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 #:

☐ Non OHIP Patient:

☐ WSIB #:

Physician Name:_____

Physician Signature:_____

OHIP Billing Physician Name/#: _____

Physician Contact #: _____

Physician Fax #: _____

Date of Referral: _____

Requested Radiologist, if applicable:

_____

PLEASE SUBMIT IMAGING ON CD WITH FINAL REPORTS

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