** LAST PATIENT REGISTERED 15 MINUTES PRIOR TO CLOSING **

SEVEN OAKS X-RAY CLINIC

106-1750 Main St., Winnipeg MB R2V 1Z7
Phone: **(204) 338-3695**
Fax: **(204) 338-9487**
Hours: **Monday - Friday**
9:00 a.m. - 12:00 p.m. • 1:00 - 5:00 p.m.
Please arrive 15 minutes prior to lunch / closing

First Name: Last Name:	Gender: ☐ Male ☐ Female
Address: City/Province Postal Code	Phone:
Manitoba Health Reg: **(Required)**	Date of Birth: DD-MM-YYYY
PHIN #: **(Required)**	Other Health Card Number: (*Out of Province*)
Pregnant? ☐ YES ☐ NO LNMP: DD-MM-YYYY _____/_____/_____	
History of allergies ☐ YES ☐ NO	
Previous Imaging:	Relevant Surgeries:

PAYMENT AGENCY RESPONSIBILITY

Manitoba Health requires that one of the following boxes be marked by the requisitioning physician at the time the x-rays are ordered:

☐ Manitoba Health ☐ Worker's Compensation Board File #_____

Third Party Requirements (specify):_____

Other (specify):_____

A medical practitioner when requisitioning x-ray procedures on a requisition form should specify individual and specify x-ray procedures. Additional views, examinations or further x-ray procedures may be performed as medically required. Comparison x-rays are not claimable in addition to the x-ray procedures performed.

Examination(s) Requested: ☐ Chest X-ray ☐ EKG

Other: 1)_____

2)_____

3)_____

Clinical History:

_____

_____

_____

Referring Physician: _____ **Date:** _____

Copy Report To: _____

IF URGENT, PLEASE INDICATE: ☐ Phone Report ☐ Fax Report ☐ Send Images with Patient

Lead shielding used? ☐ **YES** ☐ **NO**
Patient Stated NOT pregnant ☐
Technologist Initials:

PATIENTS MUST PRESENT THIS FORM AT THE TIME OF APPOINTMENT OR EXAMINATION MAY NOT BE PERFORMED.