RADIOLOGY EXPERTS

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SUBSPECIALTY RADIOLOGY SECOND OPINION REQUEST

PATIENT

Last name:	**First name:**
Date of birth (dd/mm/yyyy):	**Sex:** ☐ M ☐ F
Phone:	**Email:**
Address:	
Health card number:	

REQUESTING PHYSICIAN

Last name:	**First name:**
Phone:	**Fax:**
Email:	**Billing number:**
Copy report to:	
Physician's Signature	
Date (dd/mm/yyyy):	

PRIORITY

☐ **URGENT** (few days) ☐ **SEMI-URGENT** (1-2 weeks) ☐ **ROUTINE** (1 month)

CLINICAL QUESTION

PRIOR IMAGING

Please include study type, study date, and facility (e.g. CT head, 18 Oct 2023, BGH)