

Please fill out this form and give it to your patient.

Section 1: PATIENT DEMOGRAPHICS

Last Name:	First Name:
Address:	PHN:
City:	DOB:
Postal Code:	Gender:
Phone (Home):	Phone (Other):
	Email:

Section 2: COPY TO

OASIS Program - Vancouver Clinic 895 W 10 th Ave, Vancouver Phone: 604.875.4544 Fax: 604.875.8294	OASIS Program - Richmond Clinic Community Health Access Centre, Richmond Phone: 604.675.3644 Fax: 604.297.9926	OASIS Program - Coastal Clinic Lions Gate Hospital, North Vancouver Phone: 604.904.6177 Fax: 604.904.6170
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Section 3: NOTE TO PATIENT

Once your X-Ray has been completed, please call the OASIS clinic above to book your appointment.

Section 4: X-RAY SPECIFICATIONS

	Left	Right	X-Ray Specifications
Hip			Standing AP (weight bearing) of pelvis centered low to include prox. 1/3 femur & true lateral of hip
Knee			Standing AP (weight bearing), LAT, Skyline Patella of affected side
Ankle			Standing AP (weight bearing), lateral, mortise
Foot			Standing AP (weight bearing), lateral, oblique
Shoulder			AP, LAT, Axillary
Elbow			AP, LAT
Wrist			AP, LAT
Hand			AP, LAT

Relevant History:

Osteoarthritis

Please Print Physician Name:

Physician Fax:

Authorizing Physician Signature:

Physician billing number: