Vancouver CoastalHealth
Promoting wellness. Ensuring care.

OASIS Radiology Exam Requisition Form

OASIS OsteoArthritis Service Integration System
Working Together for Healthy Joints

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

Section 1: PATIENT DEMOGRAPHICS

Last Name: First Name:

Address: PHN:

DOB:

City: Postal Code: Gender:

Phone (Home): Phone (Work): Phone (Cell):

Section 2: COPY TO

OASIS Program - Vancouver Clinic
2775 Laurel Street, Vancouver
Phone: 604.875.4544
Fax: 604.875.8294

OASIS Program - Richmond Clinic
Richmond Hospital, Richmond
Phone: 604.244.5377
Fax: 604.244.5517

OASIS Program - Coastal Clinic
Lions Gate Hospital, North Vancouver
Phone: 604.904.6177
Fax: 604.904.6170

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: