Ministry of Health and Long-Term Care
MOBILE X-RAY / ULTRASOUND AUTHORIZATION FORM
Please fax this form for approval to:
Independent Health Facilities Program
613-548-6734

********** PLEASE PRINT CLEARLY **********

PATIENT LAST NAME: _____

PATIENT FIRST NAME: _____

OHIP # _____

DATE OF BIRTH (M/D/YYYY) _____

PHYSICIAN NAME: _____

ADDRESS FOR MOBILE SERVICE: _____

_____

_____

FACILITY PHONE #: _____

FACILITY FAX #: _____
(the response will be sent back to this number)

PERMISSION BEING REQUESTED FOR MOBILE X-RAY / ULTRASOUND FOR:

PART OF THE BODY: _____

REASON FOR X-RAY/ULTRASOUND: _____

_____

MEDICAL REASON PATIENT NOT AMBULATORY:

_____

_____

REQUESTING PHYSICIAN SIGNATURE: _____
(the referring physician must sign or the form will be returned)

MINISTRY APPROVAL & DATE: _____