MEDICAL REPORT
CHEST X-RAY REQUISITION AND REPORT

UCI #:		
IME #:		
UMI # (if applicable):		
Family name	**Given name(s)**	
Date of birth (YYYY-MM-DD)	**Country of birth**	**Gender**

PHOTOGRAPH required for all clients. Must be taken within six months of the medical examination.

Routine PA (posteroanterior) chest X-ray is required. ▶ **Date of exam:** (YYYY-MM-DD)

IMMIGRATION MEDICAL RADIOLOGY GRADING

Please consider the information you have provided about this client. You must consider if there is any evidence of TB or other significant findings. Significant means that a finding has a current or potential health impact.

☐ **A:** No evidence of active TB or changes suggestive of other significant diseases identified.

☐ **B:** Evidence of active TB or changes suggestive of other significant diseases identified.

Comments:

PANEL RADIOLOGIST DECLARATION

I have confirmed the BIODATA / Identity of the client ▶ ☐ No ☐ Yes

I have concerns about the BIODATA / Identity of the client ▶ ☐ No ☐ Yes ▶ If YES, please provide details:

I confirm that this immigration radiology examination and report is a true and accurate record of my findings.

Panel Radiologist name	Panel Radiologist no.

Panel Radiologist signature

Date YYYY-MM-DD