

Office Use Only

Appointment Date and Time: _____

Patient Health Record #: _____

Medical Imaging Requisition

Patient Name: _____	Alternate Phone #: _____
Date of Birth (dd/mm/yyyy): _____	Health Card #: _____
Telephone #: _____	WSIB#: _____

Ordering Practitioner Instructions: <ul style="list-style-type: none"> ○ For General X-rays, Gastrics, Ultrasound Mammography, fax to 519-524-8532 ○ Call Medical Imaging to inform if Stat request Isolation: <input type="checkbox"/> Contact <input type="checkbox"/> Droplet <input type="checkbox"/> Airborne	Patient Instructions: <ul style="list-style-type: none"> ○ Once requisition is received in MI booking will contact with the appointment date & time or call 519-524-8323 x5474 to book ○ Health card is required on the date of your exam
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X-RAY EXAMS Abdomen/Pelvic: <input type="checkbox"/> Single view supine/KUB <input type="checkbox"/> Acute series supine/erect <input type="checkbox"/> Pelvis Head & Neck <input type="checkbox"/> Skull <input type="checkbox"/> TM Joints <input type="checkbox"/> Facial Bones <input type="checkbox"/> Nasal Bones <input type="checkbox"/> Mandible <input type="checkbox"/> Neck for Soft Tissues Chest <input type="checkbox"/> Chest PA & Lat <input type="checkbox"/> Ribs Right Left Bilateral <input type="checkbox"/> Sternum Spine** <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> SI Joints **If ordering a Spinal Xray, please check appropriate box in Clinical Information section below. <input type="checkbox"/> Other X-ray exams _____	EXAMS Requiring an Appointment Fax Requisition to 519-524-8532 G.I. TRACT <input type="checkbox"/> Barium Swallow/Upper G.I Study <input type="checkbox"/> Modified Swallowing study – coordinated with speech path. <input type="checkbox"/> Small Bowel Follow Through <input type="checkbox"/> Double Contrast Barium Enema ULTRASOUND <input type="checkbox"/> OB U/S for IPS (11-13 weeks) <input type="checkbox"/> OB U/S for MSS/Dating (less than 16 weeks) <input type="checkbox"/> OB U/S – ROUTINE (>18 weeks) <input type="checkbox"/> OB U/S – High Risk (Complications): _____ <input type="checkbox"/> Abdomen - Complete <input type="checkbox"/> Abdomen – Limited (Specify): _____ <input type="checkbox"/> KUB (kidney/ureter/bladder) <input type="checkbox"/> Bladder <input type="checkbox"/> Renal <input type="checkbox"/> Pelvis – Complete <input type="checkbox"/> Scrotal <input type="checkbox"/> Popliteal Fossa <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Shoulder <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral <input type="checkbox"/> Thyroid <input type="checkbox"/> Venous Doppler <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Arterial Doppler <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Carotid Doppler <input type="checkbox"/> Other Ultrasound Exams: _____ <input type="checkbox"/> MAMMOGRAPHY
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Clinical Info (required): URGENT ELECTIVE	Suspected Pathology: <input type="checkbox"/> Trauma <input type="checkbox"/> Tumour <input type="checkbox"/> Infection <input type="checkbox"/> Spinal stenosis/cauda equine syndrome <input type="checkbox"/> Nerve root compression <input type="checkbox"/> Ankylosing spondylitis/inflam. condition <input type="checkbox"/> Congenital/developmental abnormality	Department use only: Tech initials _____ <input type="checkbox"/> DOB checked <input type="checkbox"/> Pt not Pregnant <input type="checkbox"/> Lead used
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REFERRING PHYSICIAN: Practitioner's Name (Print) _____ Tel: _____ Fax: _____ Physician's Signature: _____	Address: _____ Billing No: _____ Date(dd/mm/yyyy): _____
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