# IMAGING REQUISITION

## X-RAY/ ULTRASOUND/ BMD

Name:_____

ID Number:_____DOB: _____

Pt. Phone Number: (___)_____HC #_____

Clinical Information **(mandatory)**: _____

_____

_____ ☐ PRIORITY DICTATION

**Practitioner Name (please print):** _____ _____ MD RN(EC) RM PA (circle) _____

**Practitioner Phone # (mandatory):** _____ **Physician's Signature (mandatory):** _____ **Date:** _____

**Additional Copies**: _____

***IMAGING DEPARTMENT USE ONLY:***

**Date:**_____**Time:**_____a.m. p.m.

☐ Please notify your patient of this appt ☐ Your patient has been notified of this appt

| **Location:** | **Phone:** | **Fax:** |
|---|---|---|
| ☐ Seaforth Community Hospital | 519-527-8404 ext 4224 | 519-527-8427 |
| ☐ Clinton Public Hospital | 519-482-3440 ext 6255 | 519-482-8737 |
| ☐ St. Marys Memorial Hospital | 519-284-1332 ext 3329 | 519-284-8320 |
| ☐ Stratford General Hospital | 519-272-8212 | 519-272-8247 |

☐ Register in Imaging 1st floor East Building North

*PREP INFORMATION:*

- ☐ No Prep Required
- ☐ Nothing to eat or drink past midnight
- ☐ No food past midnight, Full bladder – **Finish** Drinking 6 (8oz) glasses of water 1 hour before exam
- ☐ Full bladder – **Finish** Drinking 6 (8oz) glasses of water 1 hour before exam
- ☐ See attached Prep sheet

**Is this patient:**

- ☐ An Inpatient
- ☐ In Isolation
- ☐ From a longterm care home(ie. Nursing home)_____

☐ **HOYER LIFT** needed?

## General X-Ray

**ABDOMEN:**
- ☐ Supine View(s)/KUB
- ☐ Acute series (3 views)

**HEAD & NECK:**
- ☐ Neck for Soft Tissue
- ☐ Orbits
- ☐ Nasal Bones
- ☐ Facial Bones
- ☐ TMJs
- ☐ Skull/Mandible

**CHEST:**
- ☐ Chest PA & Lat
- ☐ Ribs R L
- ☐ Sternum

**SPINE:**
- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar Spine
- ☐ Sacrum/Coccyx
- ☐ S.I. Joints

**UPPER EXTREMITIES:**

| | | |
|---|---|---|
| ☐ Clavicle | R | L |
| ☐ Shoulder | R | L |
| ☐ Scapula | R | L |
| ☐ Humerus | R | L |
| ☐ Elbow | R | L |
| ☐ Forearm | R | L |
| ☐ Wrist | R | L |
| ☐ Scaphoid | R | L |
| ☐ Hand | R | L |
| ☐ Finger 1 2 3 4 5 | R | L |

☐ Other_____

**LOWER EXTREMITIES:**

| | | |
|---|---|---|
| ☐ Pelvis | | |
| ☐ Hip | R | L |
| ☐ Femur | R | L |
| ☐ Knee | R | L |
| ☐ Tibia & Fibula | R | L |
| ☐ Ankle | R | L |
| ☐ Foot | R | L |
| ☐ Calcaneus | R | L |
| ☐ Toe 1 2 3 4 5 | R | L |

## Ultrasound

- ☐ OB dating (less than 16 wks)
- ☐ OB NT (11.5-13.5 weeks)

***North York eFTS requisition must accompany this requisition**

- ☐ OB routine (19-21 weeks)
- ☐ OB high risk (complications)
- ☐ Cord Doppler
- ☐ Cervical Length
- ☐ OB Other_____

**LMP:**_____**or EDD:** _____
**DD/ MM/ YYYY** **DD/ MM/ YYYY**
**(Mandatory)**

- ☐ Head and Neck
- ☐ Thyroid
- ☐ Carotid
- ☐ Scrotal
- ☐ Infant Brain
- ☐ Pelvic Complete (EV if appropriate)
- ☐ Popliteal Fossa R L
- ☐ DVT Leg R L

- ☐ Abdomen – Complete
- ☐ Abdomen – Limited
  - ☐ Liver
  - ☐ RUQ (HPB)
  - ☐ Aorta
  - ☐ Renal
  - ☐ Bladder

☐ Other _____

## Specials (Stratford)

- ☐ Barium Swallow
- ☐ Modified Swallowing Study
- ☐ Upper GI Series
- ☐ Small Bowel Follow Through
- ☐ Interventional PICC
  - ☐ single ☐ double
- ☐ Other _____
- ☐ Tube Check
- ☐ Hip Injection*
- ☐ Air Contrast Barium Enema
- ☐ Voiding Cystogram
  - ☐ sedated ☐ non-sedated
- ☐ Hysterosalpingogram*
- ☐ Cystogram*

**Fluoro time:**

_____min

**Dose:**

_____

☐ mGy/cm²

## Bone Densitometry

☐ DEXA Bone Mineral Density (Stratford Site)

☐ DEXA Bone Mineral Density (Clinton Site)

(Table Weight Limit 350 lbs)

*** Consent must accompany this requisition for procedures performed by Specialist**