# IMAGING REQUISITION

## X-RAY/ ULTRASOUND/ BMD

Name:_____

ID Number: _____ DOB: _____

Pt. Phone Number: (___)_____ HC #_____

Clinical Information **(mandatory)**: _____

_____

_____ ☐ PRIORITY DICTATION

**Is this patient:**
☐ An Inpatient
☐ In Isolation
☐ From a long term care home (ie. Nursing home)

**Practitioner Name (please print):**_____ _____ _____

**Practitioner's Signature (mandatory)** **Date**

Additional Copies to:_____

***IMAGING DEPARTMENT USE ONLY:***

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

☐ Please notify your patient of appointment.
☐ Your patient has been notified of this appointment.

| **Location:** | **Phone:** | **Fax:** |
|---|---|---|
| ☐ Seaforth Community Hospital | 519-527-3018 ext. 4224 | 519-527-8414 |
| ☐ Clinton Public Hospital | 519-482-3440 ext. 6255 | 519-482-8737 |
| ☐ St.Marys Memorial Hospital | 519-284-1332 ext. 3329 | 519-284-8320 |
| ☐ Stratford Medical Imaging | 519-272-8212 | 519-272-8247 |

☐ Register in Imaging 1st floor East Building North
☐ Register at Patient Registration West Building

*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

## General X-Ray

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

**HEAD & NECK:**
☐ Sinus
☐ Neck for Soft Tissue
☐ Orbits
☐ Nasal Bones
☐ Facial Bones
☐ TMJ's

**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
☐ 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
☐ Toe 1 2 3 4 5 R L

## Specials (Stratford)

☐ Barium Swallow
☐ Modified Swallowing Study
☐ Upper GI Series
☐ Small Bowel Follow Through
☐ Air Contrast Barium Enema
☐ Tube Check
☐ Other _____

☐ Hysterosalpingogram
☐ Cystogram
☐ Voiding Cystogram
☐ sedated ☐ non-sedated
☐ PICC ☐ Single ☐ Double
☐ Hip Injection

## Ultrasound

☐ OB dating (less than 16 wks)
☐ OB IPS (11.5-13.5 weeks EGA)
☐ 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)**

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

☐ Head and Neck
☐ Thyroid
☐ Carotid
☐ Scrotal
☐ Bladder
☐ Infant Brain

☐ Pelvic Complete (EV if appropriate)
☐ Popliteal Fossa R L
☐ DVT Leg R L
☐ Echocardiogram (Stratford)
☐ Other_____

## Bone Densitometry

☐ DEXA Bone Mineral Density (Clinton or Stratford)
(Please attach any previous BMD reports)