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	519-527-3018 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 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 long term 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
☐ Other _____

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

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)