

Ph: 519-727-3993 or Fax: 519-727-3939

1679 County Rd 22, Unit 1 Belle River, ON

STAT Please provide after hours number

Referring Physician Name Patient's Last Name, First Name DOB (DD/MM/YY) Telephone Signature: Healthcard Number with Version Code Appointment Date Time Billing # **INDICATION:** Phone: **ULTRASOUND By Appointment** X-RAY Walk-In MUSCULOSKELETAL CHEST **GENERAL** UPPER EXTREMITIES R L Chest PA & Lateral Abdomen RΙ Limited Abdomen Ribs 🗆 R 🗆 L Rotator Cuff Clavicle Female Pelvis (transabdominal) Sternum Elbow A-C Joints SC Joints 🗌 🗌 Wrist □ □ Shoulder Female Pelvis (transvaginal) HEAD & NECK 🗌 🗌 Hand Scapula Male Pelvis 🗌 🗌 Hip □ □ Humerus Skull Prostate (transrectal) 🗌 🗌 Hip Joint Facial Bones Elbow □ KUB (Kidneys & Bladder) Knee Nasal Bones Forearm **OBSTETRICAL** □ □ Ankle Mandible Wrist □ Early OBS/Dating 🗌 🗌 Foot TM Joints 🗌 🗌 Hand □ Anatomical Scan (18-20 Wks) 🗆 🗌 Other Wrist & Thumb Neck, Soft Tissue 2nd/3rd Trimester Include all relevant Xrays Diaits 1 2 3 4 5 Pre-MRI Orbits VASCULAR Bone Age SMALL PARTS ABDOMEN Carotid Doppler LOWER EXTREMITIES □ Thyroid R L KUB/Flat Plate 🗆 🗆 Hip □ □ Upper Limb Arterial Doppler Complete Neck inc Thyroid & Acute (3views) 🗌 🗌 Femur Salivary glands Upper Limb Venous Doppler SPINE & PELVIS 🗌 🗌 Knee Parotid Glands Lower Limb Arterial Doppler 🗌 🗌 Tibia & Fibula □ Testes/Scrotum □ Cervical Spine □ □ Lower Limb Venous Doppler Groin Thoracic Spine Ankle ☐ Hernia—Side Lumbar Spine Calcaneous BONE DENSITY Soft Tissue/Lump Sacrum & Coccyx 🗌 🗌 Foot □ □ Toe 1 2 3 4 5 (Walk-in or By Appt) Other Scoliosis Series SKELETAL SURVEY □ Baseline □ Low Risk (every 3-5 years) □ High Risk (every year) Pelvis (Full length Stitched Image) ♦R Pelvis&Hips ◇L Previous Scan Date: Location: Metastatic Skeletal Survey Sacro-Iliac Joints *NEW* CARDIAC Leg Length Scoliosis Series # of images: PREGNANCY RELEASE Tech Initials: NOVA MED **Yes No** Initials: Holter Monitor NUCLEAR MEDICINE EKG BONE SCAN NUCLEAR CARDIAC □ Exercise Stress Test □ Ambulatory Blood Pressure Total Body (\$80+HST Non-OHIP) MUGA Specific Site _ Wall Motion with EF ECHO with 12 Lead EKG Indication *REQUIRED* GASTROINTESTINAL BREAST BREAST IMAGING MAMMOGRAPHY Cardiac Stress Test Hepatobiliary ♦Treadmill Liver/Spleen ULTRASOUND □ OBSP □ Routine ♦Persantine Hemangioma **History/Indication** Diagnostic Right Left Meckel's Diverticulum ***REQUIRED***

This requisition form can be taken to any licensed facility providing healthcare services including hospitals and IHFs, such as those listed on the IHF Program website http://www.health.gov.on.ca/ en/public/programs/ihf/facilities.aspx