

## RADIOLOGY REQUISITION FORM

Appointment	DAY	MONTH	YEAR	Location
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ARRIVE 10 MINUTES PRIOR TO YOUR APPOINTMENT WITH YOUR OHIP CARD. TO AVOID A "NO SHOW" FEE, PLEASE GIVE 24 HOUR NOTICE. IF YOU ARE LATE, YOU WILL BE REBOOKED

Patient's Last Name		Patient's First Name		
Address		Date of Birth (DD   MM   YYYY)		
City	Prov.	Postal Code	Phone #	Cell Phone #
Health Card #				
Physician's Signature:				
CC Reports to:				
CLINICAL HISTORY (REQUIRED) <input type="checkbox"/> STAT <input type="checkbox"/> VERRBAL Contact # _____				

### DIGITAL X-RAY (No appointment required)

#### HEAD & NECK

- Soft tissue neck
- Skull
- Sinuses
- Orbits for MRI
- Facial bones
- Nose
- Mandible
- T.M. joints
- Adenoids
- Mastoids

#### ABDOMEN

- Plain film (K.U.B. 1 view)
- Acute (2 views) + PA chest

#### CHEST

- Chest (2 views)
- Ribs & chest P.A. (OR OL)
- Sternum

Other \_\_\_\_\_

#### SPINE & PELVIS

- Cervical spine
  - Thoracic spine
  - Lumbar (L/S) spine
  - Pelvis
  - S.I. joints
  - Sacrum & coccyx
- #### SKELETAL SURVEY
- Metastatic series
  - Multiple myeloma series
  - Arthritic series
  - Bone age
  - Scoliosis series

#### UPPER EXTREMITIES

- |                          |                          |                         |
|--------------------------|--------------------------|-------------------------|
| R                        | L                        |                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder                |
| <input type="checkbox"/> | <input type="checkbox"/> | Clavicle                |
| <input type="checkbox"/> | <input type="checkbox"/> | Sternoclavicular joints |
| <input type="checkbox"/> | <input type="checkbox"/> | A.C. joint              |
| <input type="checkbox"/> | <input type="checkbox"/> | Scapula                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Humerus                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Elbow                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Forearm                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Wrist                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Scaphoid                |
| <input type="checkbox"/> | <input type="checkbox"/> | Hand                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Finger # 1 2 3 4 5      |

#### LOWER EXTREMITIES

- |                          |                          |                  |
|--------------------------|--------------------------|------------------|
| R                        | L                        |                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Hip              |
| <input type="checkbox"/> | <input type="checkbox"/> | Femur            |
| <input type="checkbox"/> | <input type="checkbox"/> | Knee             |
| <input type="checkbox"/> | <input type="checkbox"/> | Tib. & fib.      |
| <input type="checkbox"/> | <input type="checkbox"/> | Ankle            |
| <input type="checkbox"/> | <input type="checkbox"/> | Foot             |
| <input type="checkbox"/> | <input type="checkbox"/> | Calcaneus        |
| <input type="checkbox"/> | <input type="checkbox"/> | Toes # 1 2 3 4 5 |

### BONE MINERAL DENSITOMETRY (BMD)

By appointment only. (No contrast or radioactive exam the previous week).

- Baseline († BMD)  Low risk\*  High risk (Every year)

Previous (required):  Yes  No

Where: \_\_\_\_\_ When: \_\_\_\_\_

Indication: \_\_\_\_\_ \*(3 years after first exam, then every 5 years)

## X-RAY | ULTRASOUND | BMD

LOW DOSE DIGITAL X-RAY IMAGING

### DIGITAL ULTRASOUND

By appointment only. See reverse for maps, preparatory instructions and location.

#### OPHTHALMIC

- Biometry (OR OL)
- B - mode (OR OL)
- UBM (OR OL)

#### GENERAL

- Abdomen + Pelvis + TV
  - No Transvaginal
- Abdomen + Ltd Pelvis + Bil lower quadrants
  - Appendicitis
  - AAA Screening
  - Portal Hypertension
- Abdomen only
- Kidney/PVR/Bil lower quadrants
  - Kidney only
  - PVR only

#### SMALL PARTS

- Thyroid/soft tissue neck
- Breast (OR OL)
- Axilla (OR OL)
- Parotid
- Chest (pleural effusion)
- Hernia
  - Inguinal (OR OL)
  - Femoral (OR OL)
  - Abdominal Wall
- Scrotum/Testes

#### FEMALE PELVIS (Includes TV)

- No Transvaginal
- Post Void Residual

#### MALE PELVIS

- Post Void Residual
- Transrectal Prostate/PVR/Bil lower quadrants

#### MUSCULOSKELETAL

- |                          |                          |                 |
|--------------------------|--------------------------|-----------------|
| R                        | L                        |                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder        |
| <input type="checkbox"/> | <input type="checkbox"/> | Elbow           |
| <input type="checkbox"/> | <input type="checkbox"/> | Wrist           |
| <input type="checkbox"/> | <input type="checkbox"/> | Finger _____    |
| <input type="checkbox"/> | <input type="checkbox"/> | Hip             |
| <input type="checkbox"/> | <input type="checkbox"/> | Knee            |
| <input type="checkbox"/> | <input type="checkbox"/> | Ankle           |
| <input type="checkbox"/> | <input type="checkbox"/> | Achilles tendon |
| <input type="checkbox"/> | <input type="checkbox"/> | Toe _____       |
| <input type="checkbox"/> | <input type="checkbox"/> | Plantar fascia  |
| <input type="checkbox"/> | <input type="checkbox"/> | Soft Tissue     |
|                          |                          | Location _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____     |

#### DOPPLER VASCULAR STUDIES

- Carotid arteries
- Renal arteries
- Aorta/Iliacs
- Lower Extremity
 

R	L	
<input type="checkbox"/>	<input type="checkbox"/>	Arterial
<input type="checkbox"/>	<input type="checkbox"/>	Venous
- Upper Extremity
 

R	L	
<input type="checkbox"/>	<input type="checkbox"/>	Arterial
<input type="checkbox"/>	<input type="checkbox"/>	Venous

#### OBSTETRICAL

- Dating (6 -11 wks)
- Combined NT + Anatomy (11-14 wks) + (20-22 wks)
- NT (11-14 wks)
- Anatomy (20-22 wks)
- Anatomy Twin (20-22 wks)
- Fetal growth
- Biophysical profile
- Cervical length

## X-RAY | ULTRASOUND | BMD

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

### DIAGNOSTIC IMAGING INSTRUCTION SHEET

#### NO PREPARATION REQUIRED FOR THE FOLLOWING:

- Transvaginal ultrasound only (no pelvic exam)
- Musculoskeletal ultrasound
- Thyroid ultrasound
- Doppler/Vascular
- Breast ultrasound
- Face/Neck/Chest

#### X-RAY

If there is a possibility that you are pregnant, please inform your doctor and the technologist prior to the X-ray.

#### ABDOMINAL ULTRASOUND

Do not eat or drink anything for 8 hours prior to the examination. Fat free diet on the day before the examination.

#### ABDOMINAL/PELVIC ULTRASOUND

Do not eat for 8 hours prior to the examination. Fat free diet on the day before examination. Finish drinking 1 Litre of fluid (four 8 oz glasses) 1 hour before your examination time. Do not empty your bladder.

#### PELVIC ULTRASOUND/EARLY PREGNANCY (6 - 11 weeks)

Finish drinking 1 Litre of clear fluid (four 8 oz glasses) 1 hour before examination time. Do not empty your bladder. A transvaginal study may also be requested; this involves the insertion of the ultrasound probe into the vagina for optimal visualization of the pelvic structures. The bladder will be emptied for this portion of the examination.

#### PREGNANCY (12 - 40 weeks)/NUCHAL TRANSLUCENCY (11 - 14 weeks)

No preparation required.

#### KIDNEYS/BLADDER ULTRASOUND

Finish drinking 1 Litre of clear fluid (four 8 oz glasses) 1 hour before examination time. Do not empty your bladder.

#### PROSTATE/TRANSRECTAL

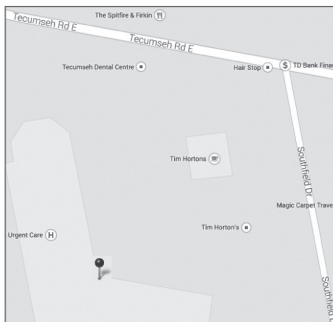
Fleet enema (2 - 3 hours prior to examination). Drink 1 Litre of clear fluid (four 8 oz glasses) 1 hour before appointment time. DO NOT go to the washroom as you must have a full bladder for the examination. You may eat regularly.

#### BONE MINERAL DENSITOMETRY (BMD)

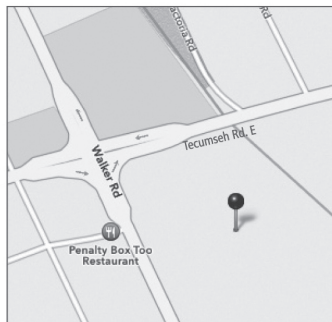
No contrast or radioactive exam the previous week. Appointment should not be booked within 1 week of having any X-ray exams involving contrast agents or having had a nuclear medicine examination. On the day of the examination, do not take calcium supplements or iron tablets.

### LOCATIONS

11811 Tecumseh Rd E, Suite 112  
Tecumseh ON N8N 4M7  
519-979-2255 | Fax: 519-979-3782



2224 Walker Rd, Suite 160  
Windsor ON N8W 5L7  
519-254-7553 | 519-254-7554  
Fax: 519-254-6054



2425 Tecumseh Rd E, Suite 108  
Windsor ON N8W 1E6  
519-258-7248 | Fax: 519-258-9408

