



IMAGING REQUISITION

X-RAY/ULTRASOUND/BMD

Name: _____

ID Number: _____ DOB: _____

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

Clinical Information (mandatory): _____

Is this patient:

- An Inpatient
- In Isolation
- From a long term care home (ie. Nursing home)

PRIORITY DICTATION

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: |
| <input type="checkbox"/> Seaforth Community Hospital | 519-527-3018 ext. 4224 | 519-527-8414 |
| <input type="checkbox"/> Clinton Public Hospital | 519-482-3440 ext. 6255 | 519-482-8737 |
| <input type="checkbox"/> St.Marys Memorial Hospital | 519-284-1332 ext. 3329 | 519-284-8320 |
| <input type="checkbox"/> 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

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 _____

CHEST:

- Chest PA & Lat
- Ribs R L
- Sternum

SPINE:

- Cervical Spine
- Thoracic Spine
- Lumbar Spine
- Sacrum/coccyx
- S.I. Joints

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

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)

- | | |
|---|--|
| <input type="checkbox"/> Abdomen – Complete | <input type="checkbox"/> Head and Neck |
| <input type="checkbox"/> Abdomen – Limited | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Liver | <input type="checkbox"/> Carotid |
| <input type="checkbox"/> RUQ (HPB) | <input type="checkbox"/> Scrotal |
| <input type="checkbox"/> Aorta | <input type="checkbox"/> Bladder |
| <input type="checkbox"/> Renal | <input type="checkbox"/> Infant Brain |

- Pelvic Complete (EV if appropriate)
- Popliteal Fossa R L
- DVT Leg R L
- Echocardiogram (Stratford)
- Other _____

Specials (Stratford)

- | | |
|---|---|
| <input type="checkbox"/> Barium Swallow | <input type="checkbox"/> Hysterosalpingogram |
| <input type="checkbox"/> Modified Swallowing Study | <input type="checkbox"/> Cystogram |
| <input type="checkbox"/> Upper GI Series | <input type="checkbox"/> Voiding Cystogram |
| <input type="checkbox"/> Small Bowel Follow Through | <input type="checkbox"/> sedated <input type="checkbox"/> non-sedated |
| <input type="checkbox"/> Air Contrast Barium Enema | <input type="checkbox"/> PICC <input type="checkbox"/> Single <input type="checkbox"/> Double |
| <input type="checkbox"/> Tube Check | <input type="checkbox"/> Hip Injection |
| <input type="checkbox"/> Other _____ | |

Bone Densitometry

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