Soldiers' MEMORIAL HOSPITAL Orillia

ISO 15189 Plus™ Accredited IQMH Diagnostic Imaging

Tel: **705-327-9127** Fax: **705-330-3224**

REQUEST FOR

# X-RAY Examination

| **PATIENT INFORMATION** | MRN N0. | **APPOINTMENT DATE:** | **TIME:** |
|---|---|---|---|
| ☐ IN-PATIENT ☐ OUT-PATIENT ☐ ER | | | **ARRIVAL TIME:** |

| Last Name | First Name | ☐ M ☐ F |
|---|---|---|

| Date of Birth (D/M/Y) | Health Card N0. | WSIB N0. | 3rd Party Ins. N0. |
|---|---|---|---|

Address

| City | Postal Code | Contact Number | ■ OK to leave voice mail message |
|---|---|---|---|

Patient is able to give consent for this procedure: ☐ Yes ☐ No

Does the patient have a glucose monitoring device? ☐ Yes ☐ No

If patient unable to give consent, please ensure SDM attends with the patient and has appropriate documentation.

☐ SDM Name: ☐ SDM Contact Information:

☐ Patient requires assistance to complete this imaging exam, *e.g. mobility, translation* Please Specify:

### Head & Neck

- ☐ SKULL
- ☐ MANDIBLE
- ☐ TMJ JOINTS
- ☐ ORBITS
- ☐ NASAL BONES
- ☐ FACIAL BONES
- ☐ SOFT TISSUE NECK

### Chest & Abdomen

- ☐ CHEST 2 VIEWS (PA & Lat)
- ☐ RIGHT RIBS (Incl. Chest PA View)
- ☐ LEFT RIBS (Incl. Chest PA View)
- ☐ STERNUM
- ☐ S-C JOINTS
- ☐ ABDOMEN/KUB
- ☐ ABDOMEN 3 VIEWS (Incl. PA CXR)

### Gastrics

*Must be ordered by a surgeon.*

- ☐ UPPER GI SERIES
- ☐ BARIUM SWALLOW
- ☐ SMALL BOWEL FOLLOW-THRU

### Lower Extremities

| R | L | |
|---|---|---|
| ☐ | ☐ | HIP |
| ☐ | ☐ | FEMUR |
| ☐ | ☐ | KNEE |
| ☐ | ☐ | PATELLA |
| ☐ | ☐ | TIB-FIB |
| ☐ | ☐ | ANKLE |
| ☐ | ☐ | CALCANEUS |
| ☐ | ☐ | FOOT |
| ☐ | ☐ | TOE ☐1 ☐2 ☐3 ☐4 ☐5 |

### Ortho Examinations (Requires Ortho Referral)

- ☐ ORTHOROENTGENOGRAM
- ☐ BILATERAL STANDING FEET & ANKLES
- ☐ VALGUS STRESS VIEW OF THE KNEES

| R | L |
|---|---|
| ☐ | ☐ |

### Upper Extremities

| R | L | |
|---|---|---|
| ☐ | ☐ | CLAVICLE |
| ☐ | ☐ | A.C. JOINTS |
| ☐ | ☐ | SCAPULA |
| ☐ | ☐ | SHOULDER |
| ☐ | ☐ | HUMERUS |
| ☐ | ☐ | ELBOW |
| ☐ | ☐ | FOREARM |
| ☐ | ☐ | WRIST |
| ☐ | ☐ | SCAPHOID |
| ☐ | ☐ | HAND |
| ☐ | ☐ | FINGER ☐1 ☐2 ☐3 ☐4 ☐5 |

### Spine & Pelvis

- ☐ CERVICAL SPINE
- ☐ THORACIC SPINE
- ☐ LUMBAR SPINE
- ☐ S.I. JOINTS
- ☐ SACRUM & COCCYX
- ☐ PELVIS
- ☐ SCOLIOSIS 1 VIEW (AP)
- ☐ SCOLIOSIS 2 VIEWS (AP & Lat)
- ☐ SKELETAL SURVEY (Metastases)
- ☐ ARTHRITIC SURVEY
- ☐ SKELETAL SURVEY (non-trauma)

**OTHER EXAM NOT LISTED:**

**RELEVANT CLINICAL HISTORY FOR EXAM:**

| **Physician's Name** (Please PRINT clearly) | |
|---|---|
| **Phone** | **CPSO#** |

Physician's Signature

**INCOMPLETE, ILLEGIBLE AND/OR UNSIGNED REQUISITIONS WILL BE RETURNED.**